

INSTITUTIONAL CONTEXT OF TRUST

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Master of Business Administration

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2001

A research project submitted to the School of Graduate Studies Council of the University of
Lethbridge in partial fulfillment of the requirements for the degree

MASTER OF SCIENCE IN MANAGEMENT

The University of Lethbridge

Lethbridge, Alberta, Canada

August 2002

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Abstract

The dynamics of trust have perplexed academicians and practitioners alike. However, it continues to remain as an elusive and evasive area of study. The perception of trustworthiness in times of change has social dimensions attached to it. An institutional framework to understand this process of change in conjunction with the traditional theories of trust provides a fresh approach to understand these social intricacies. This paper argues that trust and institutional logics are not monolithic entities. Institutional logics are best understood through mental scripts. A mental script is an individual's socially shared cognitive belief about what is the appropriate social behavior. Mental scripts on the norms of appropriate behavior may vary across the various subgroups within an organization. Such a variance of institutional logics may also explain the varying levels of trust among organizational members.

Acknowledgements

This research project is in its present form largely on account of the unconditional support I have received from Ali and Jay.

Ali was an envisioning and empathetic supervisor. His cheerful disposition and critical insights helped to add value to my research. I have learnt a lot from his humility and extremely high energy levels. His encouragement, approachability, assistance with resources and faith in my abilities enabled me significantly in this research endeavor.

Jay was an inspirational guide who was always driving me to attain higher standards. His enthusiasm in my work was much appreciated. I have learnt a lot about interpretive research on account of his limitless patience and frequent feedback on my work. His contribution to this study has been very significant.

I am grateful to my classmates Bruno, Rob and Renee for being the rater-analysts of my study. Their analysis was vital for this project. I am thankful to Mike Basil for helping me analyze the quantitative part of my study. Mike has been very positive and approachable during the course of my research. I also express my gratitude to Dr. Paul Hasselback of the Taber Primary Integrated Project and the Taber Research project team at the University of Lethbridge for permitting me to use the interviews. Other faculty and staff members to include Bob Boudreau, Linda, Helen, Samia, Pam, Sarah, Abdie (Department of Sociology) and Scott Allen (Department of Psychology) have helped me in the course of my research.

And finally, I am grateful to my wife Arunima for setting an impeccable standard of academic merit and industriousness for me to emulate.

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Chapter One: Introduction

The dynamics of trust have perplexed academicians since decades. Economists tend to focus on the transactional dynamics of trust, sociologists believe that such trust is embedded in relationships and psychologists focus on internal cognition (Rousseau, Sitkin, Burt & Camerer, 1998). There is a growing recognition of the importance of trust in times of crisis, change and conflict (Mishra, 1996; Tyler & Degoey, 1996; Webb, 1996). Trust has been acknowledged as an important resource for teamwork and cooperative behavior (Jones & George, 1998; Kramer, 1999; McAllister, 1995; Powell, 1995; Tyler & Kramer, 1996, Williams, 2001). Literature also supports the role of cooperation for management success (Korsgaard, Schweiger & Sapienza, 1995; Ring & Van De Ven, 1994; Smith, Carroll & Ashford, 1995). Such cooperative behavior and social relationships within an organization that makes it work effectively is often referred to as social capital (Prusak & Cohen, 2001, p. 86). Leana and Buren III (1999) suggest that operationalizing the construct of trust is important to understand the dynamics of organizational social capital. This proves to be a daunting task as the literature on trust often ignores the institutional context of organizations.

Recently there has been considerable interest in the application of institutional theory to organizational change (e.g. Dacin, Goodstein & Scott, 2002; Greenwood, Suddaby & Hinings, 2002; Hoffman, 1999). An institution may be looked upon as something that is embodied by its cultures, social structures and routines (Scott, 1995, p. 52). An institution is an entity that is “infused with values” and these values lend it to “social integration” (Peters & Waterman, 1982, p. 99). Scott (1987) refers to the

influential article on institutionalized organizations by Meyer and Rowan (1977) who conceptualize that institutionalization is a process in which social processes “come to take on a rule like status in social thought and action” (p. 496). These thoughts and actions are important for organizations to evolve and change, as organizations are not merely “technical systems” but also have social dynamics (p. 507). Zucker (1991) suggests that any resistance to change is directly related to the process of institutionalization. Others argue that legitimacy enables an organization during periods of change (Sherer & Lee, 2002; Glynn & Abzug, 2002; Oliver, 1991). However, this process of institutionalization is difficult as different institutional actors within an organization are driven by different institutional logics.

Institutional logics may be looked upon as sets of “material practices and symbolic construction...which constitute their organizing principles” (Friedland & Alford in Scott et al, 1997, p. 14). There is a growing consensus among institutional analysts that all organizations operate under one or more sets of institutional logics (Scott, Mendel & Pollack, 1997). Friedland and Alford (1991) make a mention that “institutional contradictions” exist in many institutions where diverse forces work simultaneously. In the context of healthcare in Canada, at one end of the spectrum is the institutional logic of efficiency that is driven by norms of rationality and economics. Scott et al (1997) refer to this form of institutional logic as *managerial or corporate logic*. A contradictory logic at the other end of the spectrum suggests that empathy, equity and quality of care are the appropriate institutional logic.

The current problem existing in both institutional literature and the literature of trust is that it recognizes the interrelationship between the two constructs. However, such

relationships need to be developed a bit further. To give an example from institutional literature:

Institutional participants and external constituents alike call for institutional rules that promote confidence in trust and confidence in outputs and buffer organizations from failure (Emery & Trist, 1965 in Meyer & Rowan, 1991, p. 55).

Even though a mention of adopting institutional rules to inspire trust has been made, institutional literature is largely silent on these holistic dimensions of trust. In a similar vein, literature on trust is replete with examples of values and their impact on trust. Certain examples include “perceived value incongruence” between two parties (Sitkin & Stickel, 1995, p. 211); “values” relating to the persons value system and norms of correct behavior (Jones & George, 1998, p.532); “social conceptions of trust” based on values and morality (Tyler & Kramer, 1996, p.5); and “identification based trust” in which there is a shared understanding and acceptance of common goals (Lewicki & Bunker, 1996, p.122).

This paper argues that institutional logics and trust are not necessarily monolithic entities. The social dimensions of trust as an orientation towards the society beyond rational considerations of trust sparingly occur in the literature (Kramer, 1996). Even when the literature on trust refers to values and norms of appropriate behavior as discussed above, it is often silent on how to integrate this with the traditional models of trust. This study proposes that dynamics of trust within a not-for-profit social organization such as hospitals in Canada are best understood in an institutional bound context, as theories of trust are primarily transaction-based or based on past interactions within an organization. Institutional theory addresses these inadequacies, as it is a

socially bound theory. It is therefore argued that the operationalization of the construct of trust to understand the dynamics of social capital at the organizational level must also take into consideration its institutional context. Such institutional dynamics of trust are best understood through institutional logics.

Overview and Background of the Study

Health services in Alberta have undergone tremendous changes over the last decade with the dissolution of the erstwhile hospital boards. They are now delivered by 17 regional authorities, two provincial health authorities, and health professionals who provide service-for-fee and other related practitioners who provide supplies and equipment (Alberta Health and Wellness, 1999). The healthcare organizations across Alberta are now under pressure to perform their tasks efficiently, without wastage and within budget. Under the past system, the physicians in Taber were paid on a fee-for-service basis, as is the case in the rest of Alberta. However, this pilot project at Taber is experimenting with a new model of healthcare delivery.

The changing nature of healthcare in Canada. Healthcare is undergoing major reforms in Canada since the 1990s largely in response to significant reductions in transfer payments from the federal government (Stassen, Cameron, Mantler & Horsburgh, 2001). These reforms led to the regionalization of health services and the dissolution of hospital boards. The changing socio-economic milieu has necessitated a more efficient and cost-effective approach towards healthcare. This restructuring of the organizations and

reengineering of its business processes involves the need to abandon past practices so as to meet the current mandate (Walston, Urden & Sullivan, 2001).

The overall goals for health policy in the current era are increased access, quality and cost containment (Rich, 2002). At the other end of the spectrum is the Canada Health Act, which guarantees equitable healthcare opportunities to all its residents and lies at the root of the socialistic principles of the constitution. Change management in the healthcare sector has become a very tense and delicate issue. These changes are impacted by both tangible and intangible factors. The tangibles consist of facets such as business and clinical elements of healthcare that can be measured statistically. However, a large number of failures occur due to the intangible factors also referred to as the “soft side” or “the touchy- feely stuff” (Atchison, 1999).

The nature of healthcare makes it imperative for it not to be treated as another free market industry that is guided by competitive forces. However, conflicting objectives and the ever-rising medical costs necessitate significant improvement to attain efficiency and improvement (Beckman & Katz, 2000). The challenges stemming from an aging population, shortage of clinicians and rising costs are only bound to exacerbate the current frustrations of the health care administrators (Baker, 2002). It is also believed that in the future the healthcare system will use social capital when developing partnerships (Holm & Burns, 2000).

The percentage of Canadians who trust the federal government to do the right thing currently stands at 27 percent (CBC, 2002). Such distrust is too severe to ignore and is existent even within organizations. Building of social capital therefore becomes a serious issue. This trust is deeply embedded in the processes and the overall feel of the

organization. It manifests itself in loyalty and cooperation that leads to success (Swanson, 2001). Healthcare organizations are now required to be more accountable on account of the declining trust. They are being constantly monitored to ensure that they remain true to their mission and purpose (MacStravic, 2002). These changes are serious in nature as they seek to address the core issues of quality of healthcare and safety of patients (Cudney, 2002). The decline of public health facilities on account of diminishing resources is leading to a betrayal of trust all over the world in their respective health initiatives (Laurie, 2002).

Taber Integrated Primary Project (Taber Project). A regional healthcare organization in a southern Alberta community is undergoing a process of change. This intended change has initially been directed towards Primary Care and the project is known as the Taber Integrated Primary Project. This project is initiating a process of transformation from what it symbolizes as “sickness model” to a “wellness model” of healthcare delivery. This change emphasizes the need for integration, preventive practices and a more efficient system of delivery of health services to the community. The organization recognizes the need for efficiency and yet cannot ignore expectations related to quality of care.

In Taber, the three major changes that are taking place are the restructuring of the organization, changes in the reward system and enhanced information systems (Dastmalchian & Janz, 2001). These changes endeavor to provide healthcare facilities in a more effective and efficient way. The physicians’ clinics have moved to the hospital

and they are now in a leadership role with incentives to manage the healthcare resources in an efficient manner.

Research Problem

In times of change, trust is essential for cooperation and in turn organizational social capital. The research problem stems from the argument that the understanding of the dynamics of trust is multi-faceted and has many dimensions. This paper acknowledges the social nature of organizations. It argues that understanding these social processes in change is both complex and mired in contradictions. These social facets of organizations transcend beyond structural changes in an organization or the reengineering of its business processes. Operationalizing trust in such a research setting is therefore both challenging and complex. The trust the employees repose in the organization in these times of change may stem from their past experiences, the perceived trustworthiness of the organization, and their status in the new system and also their institutional logics of appropriate behavior.

Change brings forth a new set of power equations and uncertainty in the lives of the employees who have to adjust and adapt to a new work environment. The employees of the Taber Project at all levels, including managerial and non-managerial, each have a different set of ideals, values, beliefs and expectations from the system. At the heart of the research problem is an institutional change process in which there is a clash of cognitive belief systems (also referred to as institutional logics). This clash of institutional logics has an impact on the change process. These logics are best understood by understanding the mental scripts of the constituents involved. A mental script is an

individual's cognitive belief about what is the appropriate social behavior. In this study it would be the informants' perceptions on healthcare. These informants happen to be the employees of the pilot healthcare project at Taber. In any organization there exist 'situated institutions' in the form of various groups of people with competing values, ideas and beliefs also referred to as competing institutions (Hoffman, 1999).

Purpose of the Study

This research project aims to operationalize trust from an institutional perspective in the context of change. More specifically, the purposes of this study are:

- (1) To operationalize the construct of trust in the context of change and determine whether trust emerges as an underlying issue. This project also seeks to understand the issues that impact such feelings of trust in its members and explore if patterns of trust vary across the organization.
- (2) To understand the mental scripts of the employees and explore their views on the appropriate norms of healthcare delivery. This process will enable a more coherent understanding of institutional logics; as such logics are best understood through a shared understanding between the members, also referred to as mental scripts.
- (3) To understand the impact of institutional logics on the dynamics of trust.

Significance of the Study

Healthcare in Canada has been a source of much debate and controversy. This project is significant due to the following reasons:

- (1) This paper integrates the literature on institutional theory, trust and social capital in a coherent manner. It also capitulates these constructs in a fairly unique methodological manner, details of which are discussed in the chapter on methodology.
- (2) It seeks to operationalize the construct of organizational social capital. Leana & Buren (1999) highlight that the operationalization of trust at the organizational level would be a valuable contribution to the literature and also help to examine the organizational social capital model.
- (3) From a practitioner perspective, this research endeavor is significant, as it is important for them to garner all the support of its employees in order for these changes to be successful. Also, in light of the increasing shortage of doctors and nurses, and their unwillingness to work in rural area, this research project will enable them understand the repercussions of such contradictions that exist within the organization.

Literature Review

Trust is a complex phenomenon that has many dimensions. This research project argues that trust varies across subgroups and that these dynamics of trust are best understood in an institutional context. The operationalization of trust at the organizational level would be considered to be a significant contribution to the literature on social

capital (e.g. Leana & Buren III, 1999). In order to operationalize trust it is important to understand the construct of trust and to prove beyond reasonable doubt that institutional logics differ across subgroups. Hence, the review of literature seeks to systematically explain the constructs that would affect the dynamics of trust.

Social Capital. The first construct of this study is social capital. A review of literature reveals that social capital may be an attribute of individuals, organizations or communities. The three themes that emerge most commonly from the review of literature of social capital are community, networks and trust. The review of literature on social capital has been done with a historical perspective to add richness to this study.

The early developments in ideological thought of social capital can be attributed to Tocqueville who visited the United States in the 1830s and was struck by the capacity of Americans to constantly form associations. Ferdinand Tonnies (1855- 1936) referred to the concepts of ‘Gemeinschaft’ and ‘Gesellschaft’ in understanding the role of the community and the society. Durkheim (1858-1917) highlighted the importance of civic morality and ethics in a given society. Durkheim (1957) was a French philosopher and is well known for his work ‘The Division of Labour in Society.’ Durkheim (1883) refers to morality at various levels to include that at the individual, domestic, social and civic level. Karl Marx (1818-1883) along with his colleague Engels made a significant contribution to the role of socialism and communism in its extreme form. Often social capital is mistaken, as an extension of socialism and it is important to recognize that this is not the case. Marx and Engels in their book titled ‘Capital’ (1952) which is a translated

version of Das Kapital, only make a reference to capital in the form of financial capital and human capital in the form of a laborer who gets paid wages for his efforts.

It has become increasingly common to apply the concept of social capital across a number of sectors to include healthcare (Adler & Kwon, 2002; Putnam, 2000 and also see World Banks social capital website). Putnam (2001) talks of the declining social capital in Americans by highlighting that the proportion of Americans who reply that they “trust the government in Washington” only “some of the time” or “almost never” has risen steadily from 30 percent in 1992 to 75 percent in 1996. Putnam (1993) refers to the regional governments in Italy that were established in 1970 and speaks of the differences in the quality of governance provided by them on account of the differences between the civic associations and trust existing within these two societies.

In a later work titled ‘The Strange Disappearance of Civic America’ Putnam (1996) refers to the crucial age between 14 and 18 where education and awareness make an impact on the perceived trustworthiness of a child in his environs. He also argues that networks and trust help in the pursuance of shared objectives. Putnam’s primary area of interest in measuring social capital is talking about community issues of which trust is an essential part. His contribution to the development of the concept of social capital is significant, as his works have brought this issue to the forefront. It has now been defined in various ways and has many ramifications. Javidan & Varella (2002) go a step further in the development of literature and explain the impact of charismatic leadership from a social capital perspective.

Adler and Kwon (2002) make an interesting comparison of the literature across the ages and come up with the basic themes of social capital. Certain key definitions as

highlighted by Adler & Kwon (2002) include those by Fukayama (1990) who refers to social capital as “the ability of people to work for common purposes in groups and organizations.” Some of these themes are its influence on career success, assistance in finding jobs, enhancing product innovation, strengthening of supplier relations and various other impacts on social capital. They argue that social ties lead to networks and a better support system.

Interestingly, Putnam (2002) talks of the rise in levels of trust in the government in the aftermath of the September 11, 2001 tragedy in his book ‘Bowling Together.’ Social capital may be seen as interpersonal trust exposed through the relationships that exist among a society’s members, its institutions and organizations (Reid and Salmon 2000). Prusak and Cohen (2001) argue that stocks of social capital such as trust, norms, and networks, tend to be self-reinforcing and cumulative. They believe that successful collaboration in an endeavor builds connections and trust, and these social assets facilitate future collaboration. Norris (2001) proposes that there exist structural and cultural dimensions of social capital. The structural dimensions of social capital include facets such as institutional membership and the cultural dimensions are measured in terms of feelings of social trust.

For the purposes of this study the framework of organizational social capital as provided by Leana and Buren III (1999) is being adopted. They define organizational social capital as:

A resource reflecting the character of social relations within the firm. Organizational social capital is realized through members’ levels of collective goal orientation and shared trust, which create value by facilitating successful collective action. Organizational social capital is an

asset that can benefit both the organization (e.g. creating value for shareholders) and its members (p. 538).

This implies that if there is ‘trust’ in the organization and the employees share a common set of values and beliefs, and work towards common objectives, the organization possesses a high level of social capital. Thus, such capital is embedded in the social nature of the firm. The norms of trust will be explored by a review in the succeeding paragraphs. Such operationalization of trust is important to the organizational social capital literature and is grounded in the literature of social capital.

Trust. “Trust is one party’s willingness to be vulnerable based on the belief that the latter party is (a) competent (b) open (c) concerned, and (d) reliable” (Mishra, 1996, p. 265). A review of the literature on trust reveals fairly broad and varying facets of trust. Some suggest that as trust arises out of vulnerability, people tend to maximize their sense of security as explained by the “self-interested behavior of agents” (e.g. Hendry, 2002, p. 98).

Taking this argument a little further is the *rational choice model*, which argues that people seek to maximize their personal gains and minimize their personal losses in any transaction (Tyler & Kramer, 1996). Kramer (1993) characterizes individuals in a trust relationship as “intuitive auditors” (Tyler & Kramer, 1996)). He also refers to the power-status relationships on the perceptions of trust. Kramer (1999) mentions that even though the rational choice model of trust has found much acceptance among researchers, the *relational model* may perhaps provide a better framework. He suggests, “Trust needs to be conceptualized not only as a calculative orientation towards risk, but also social

orientation toward other people and toward society as a whole” (p. 573). Individuals are therefore not merely interested in their own personal gains. Rather, the dynamics of values and appropriateness of social behavior also has an impact on their feelings of trust.

Jones and George (1998) propose that trust be determined by “the interplay of people’s values, attitudes, and moods and emotions” (p.531). The failure to meet the minimum levels of trust in any organization may actually amount to measurable dollar costs associated with this failure (Creed & Miles, 1996). Burt & Knez (1996) argue that trust builds incrementally while distrust has a more catastrophic quality. Such failures result to the “betrayal” of trust in organizations (e.g. Elangovan & Shapiro, 1998). Barrett & Hinings (2002) propose that trust and control relations are important determinants within the context of institutional change. Bradach & Eccles (1989) suggest that trust is one of the three forms of control mechanism; the other two being price and authority. Powell (1996) makes a reference to the rising interest in the field of trust and its relationship with cooperation deemed for organizational success. A belief that the system is fair enables trust in the leadership (Korsgaard et al, 1995). Trust arises out of a sense of dependency on other people and therefore when there are needs in an organization or a relationship that has social needs, trust becomes an imperative issue (Kipnis, 1996).

Lewicki & Bunker (1996) propose a model of three types of trust in a professional framework, namely “calculus-based trust,” “knowledge-based trust” and “identification-based trust.” Calculus-based trust arises out of a fear of consequences if the mutually accepted code of conduct is broken and is deterrence based. Knowledge-based trust develops over a period of time and is based on the available information and takes into consideration the history of past interactions. Identification-based trust arises out of

identification with others' desires and motives. Commonly shared values and beliefs may also lead to this sense of identification and trust based on this premise leads to cooperative behavior. This third type of trust is most difficult to obtain and occurs in a few relationships only.

The literature on trust suggests that the three critical components of it as highlighted by most researchers are *ability*, *benevolence* and *integrity* (Mayer, Davis and Schoorman, 1995). *Ability* is best explained by the terms *competence*, *business sense* and *judgment*. *Benevolence* implies the extent to which a person is willing to do something apart from an egocentric profit motive. Feelings of kindness and concern for the welfare for another are central to benevolence. *Integrity* implies following a set of principles at both a moral and personal level. Becker (1998) further clarifies that “honesty is a necessary but not sufficient condition for integrity...To have a degree of integrity a person must act on a code of morally justifiable, rational principles- not merely a single principle” (p. 158). Thus, integrity is a more holistic phenomenon and in the context of this study it implies that the organization through its leadership and management is perceived to be ethical and moralistic in its dealings (Warren, 2000). In a similar vein, some managers pretend to be nicer than they actually are and such behavior creates suspicion in the minds of the employees (Clark & Payne, 1997). Hence, behavioral integrity is the “perceived degree of congruence between the values expressed by words and those expressed through action” (Simons, 1999, p. 90).

Mayer & Davis (1999) argue that perceived *ability*, perceived *benevolence* and perceived *integrity* have independent influences on employee trust in the management activities. It is therefore important to understand the antecedents of trustworthy behavior

in the actions of managerial staff (Whitener, Brodt, Korsgaard & Werner, 1998). McAllister (1995) suggests that the two dimensions of trust are affect based and cognition based. Affective foundations for trust stem from factors such as emotional bonds, care and a concern for welfare of an individual by another. Cognition based trust on the other hand may stem from cultural similarity, reliability as demonstrated from past performance and professional competence of the individual. It is believed that the highest form of trust is “faith” and that requires the foundation of a very strong relationship or affective attachment (Rempel, Holmes & Zenna cited in Williams, 2001, p. 379). A diverse argument suggests that a balance between trust and distrust is desirable in business relationships. Thereby, “optimal trust” should be the focus of researchers (Wicks, Berman & Jones, 1999).

Sheppard & Sherman (1998) define trust in terms of “accepting the risks associated with the type and depth of the interdependence inherent in a given relationship” (p. 422). Literature differs on whether trust builds over time or high trust levels characterize initial relationships. It is however pertinent to recognize that the most critical time to develop trust is in the beginning of a relationship (McKnight, Cummings & Chervany, 1998).

Whitener et al. (1998) define trust as follows:

First, trust in another party reflects an expectation or belief that the other party will act benevolently. Second, one cannot control or force the other party to fulfill that expectation. Third, trust involves some level of dependency on the other party so that the outcomes of one individual are influenced by the actions of another (p. 513).

They explain that on account of changes in organizational structures, more than ever before the effectiveness of a manager depends on their ability to gain the trust of

their employees. Recent studies also highlight the role of building trust by transformational leaders (Pillai, Schriesheim & Williams, 1999). Even though trust has been recognized as one of the fundamental features of interpersonal relations and as essential to facilitate cooperative behavior and teamwork, it has not received much attention until recently (Sitkin & Stickel, 1996). It is believed that teams perform better when they trust the leadership as it enables the members to accept and obey the decisions and directions of the leader. In contrast, trust between the members of the team leads to better team performance (Elsass, 2001).

Trust is a “complex multidimensional construct” and yet little discussion has taken place on how the emotional, moral and cognitive attributes of trust interact and thereby determine subsequent behavior and expectations (Jones & George, 1988, p.532). Williams (2001) attempts to explain the affective-cognitive account of how group membership influences development of trust even between people from dissimilar groups. In such instances good communications between employees and the management is crucial (Sparks, Faragher & Cooper, 2001). Also, it is essential to emphasize internal communications during changes and the organization should state clear expectations regarding profitability and support of unprofitable business units (Egger, 2001). In this study one can therefore argue that if financial efficiency is one of the motives of the organization, the management at Taber should state it categorically.

Institutional change. Change is a difference in “form, quality or state over time in an organizational entity” (Van de Ven & Poole, 1995, p. 512). Jepperson (1991) refers to an institution as a social order and institutionalization as the process to reach such order.

Scott (1995) suggests that institutions are socially constructed and maintained by the individual actors and yet it assumes a disguise of a cold, impersonal and an objective reality. He defines institutions as:

Institutions consist of cognitive, normative and regulative structures and activities that provide stability and meaning to social behavior. Institutions are transported by various carriers- cultures, structures and routines- and they operate at multiple levels of jurisdiction (p. 33)

Various theorists claim that one of these three pillars also referred to, as cognitive structures, normative structures and regulative structures are more central to institutions than others. *Regulative pillars* of institutions consist of legislation, rules, policies and punishment or reward systems. The economists in particular tend to subscribe to viewing institutions as resting on the regulative pillars where “force”, “fear” and “expedience” are the central ingredients. An example would be the use of rewards and punishments to ensure conformity and adherence to institutional objectives. The sociologists who argue that institutions comprise of ‘values’ and ‘norms’ subscribe to *normative pillars*. These define the various rights and responsibilities and enable social action. *Cognitive pillars* of institutions emphasize the roles of social identities and take the cognitive dimensions of human existence seriously. The anthropologists and a certain section of sociologists attach significant importance to these cognitive elements. They argue that various actors construe various social realities as relevant to them. An example would be way firms pursue profits and academicians pursue publications as a measure of success. These socially constructed realities may be at both an individual and a collective level. They

further recognize and attach importance to the roles of sense making in organizations (e.g. Dutton & Dukerich, 1991) also referred to as scripts (Scott, 1995).

It is this third pillar of institutions namely the cognitive pillar that is being adopted for the conduct of this study. Townley (2002) used Weber's framework of rationality to illustrate the competing rationalities that exist between the actors in the context of an institutional change, where there is a clash of values between the cultural and economic. Taking a similar argument further, Seo and Creed (2002) suggest that institutional contradictions are often the drivers of institutional change but may not necessarily lead to such change. Conversely, if different subgroups within an organization enact different institutional practices it may lead to "deinstitutionalization" (Zilber, 2002, p. 251).

We often perceive particular classes of individuals automatically and put them in distinct categories (Macrae and Bodenhausen, 2000). Using this analogy they give the example that a "librarian" immediately activates the characteristics of "shy," "studious," and "responsible." In the case of this study one may be similarly tempted to categorize nurses as care givers and managers as driven by modes of efficiency and rationality. The rationality critique is gaining significant attention in the field of social sciences as this trait distinguishes human beings from animals. While making a rational choice the actors do not have clear preferences and this construction of preference is influenced by the nature and context of the decision (Shafir & LeBoeuf, 2002). Leeder (1998) uses a framework of Claus Offe to explain how the state, market and community interest clash in the process of change. This "soulcraft" in the age of brutal markets is profoundly influenced by the corporatization of our institutions that are driven by egocentric economic considerations that often ignore moral values (Johnson, 1997).

Bureaucratization as suggested by Weber can be seen as a clear example of the institutionalization of any organization. However, Weber also argued that bureaucracy was too efficient and powerful means of controlling men. He further warned that the rationalist order propelled by bureaucracy was like an “iron cage” from which there was no escape. This penchant for rationality leads to more bureaucratic structures where even the administrations at hospitals and universities start resembling the management-for-profit firms (DiMaggio & Powell, 1996). Meyer and Rowan (1991) suggest that organizations are not as institutionalized as they appear to be. Rather, organizations go through a process of “decoupling” and maintain gaps between their structures and work environments so that their formal structures cannot be evaluated. The use of ambiguous goals and avoidance of integration are a such activities that institutions indulge in during this “decoupling” process.

In the context of this study, one may hypothesize that the institutional change being exhibited by the change in the organizational structure is symbolically represented as the ‘Wellness Model’ that endeavors to legitimize the new model of healthcare delivery at Taber Integrated Care Project. This symbolic phrase is used as the means to add to the aura of confidence and to legitimize the system. The use of changing organizational names to attain legitimacy is also supported by empirical studies (Glynn & Azbug, 2002). “New institutions arise when organized actors with sufficient resources (institutional entrepreneurs) see in them an opportunity to realize interests that they value highly” (DiMaggio in Scott, 1995, p. 72). Greenwood & Hinings (1993) define the concept of archetypes and the need for coherence between these interpretive schemes and structural attributes in times of change.

The institutional approach unlike the transactions cost economics (TCE) approach is not merely driven by a purely economic rationale. Rather, it attaches importance to the social construction of human behavior (Martinez and Dacin, 1999). This researcher has evidence on the difficulties in carrying out these changes in the form of statements made by certain employees such as:

What we are doing in Taber is being tried all over the world so it's not like we are inventing some wonderful reform...But I am amazed at how much harder it is to implement than I expected it to be.

The effective implementation of these changes therefore lies at the heart of any change process. In this study I will be exploring the dynamics of trust in times of change.

Trust in the context of change. The role of “interests” and “value commitments” is central to the process of change (Greenwood & Hinings, 1996, p. 1033). Roles of trust and value commitments for attaining organizational coherence are also considered essential when an organization is moving from one archetype to another (e.g. Helco & Wildavsky in Greenwood & Hinings, 1988, p. 298). Van de Ven & Poole (1995) refer to changes of the nature similar to the ones being faced by the healthcare sector as “teleological change”. These kinds of change are unlike a life-cycle theory or developmental process where there is a necessary sequence of events. Rather, it assumes that the entity is both purposeful and adaptive either by itself or in interaction with others. Thus, the entity constructs an envisioned end state, takes action to reach it and monitors its progress.

“Volatility” in organizations characterized by frequent changes erodes relationships and organizational social capital (Prusak and Cohen, 2001). In fact the connection between social capital and trust is again too obvious to be missed. Applying the micro level aspects of macro institutional change by taking into consideration the concepts on institutional theory and script development also appears to be in order (e.g. Johnson, Smith & Codling, 2000). The use of institutional theory’s emphasis on the cultural influences on organizational change is also applicable, as healthcare organizations have complex systems and it is difficult to evaluate them merely on their technical effectiveness (Wells, 2001). In his book titled “Working with Emotional Intelligence” Goleman highlights role of emotional intelligence (EQ) and emotional competence towards achieving organizational goals (Krone & Dougherty, 1999).

Trust becomes even more pertinent in times of crisis because of the uncertainty and dependence that alleviates on account of crisis (Webb, 1996; Tyler & DeGoey, 1996). “Anticipation” is a process linked to change (Isabella, 1990). In times of crisis the levels of trust may be directly related to factors such as decentralization of decision-making, openness in communication and collaboration (Mishra, 1996). At the core of this change process is a clash of institutional logics that are better understood through mental scripts.

Mental scripts. Scripts are a person’s cognitive belief of what is appropriate social behavior (Johnson et al, 2000). The role and importance of attitudes, opinions, views and perceptions is considered significant by social psychologists and sociologists alike, who seek to understand the way people think and perceive happenings. There has also been a distinct and noticeable cognitive turn in the field of management studies over the last

decade. Researchers from various fields are now trying to understand the relationship between knowledge, social context and human activity (Porac & Glynn, 1998; Wofford, 1994). The two major issues in the study of organization behavior revolve around the understanding of human behavior in organizations and influencing such behavior to attain effectiveness in the work context (Gioia and Manz, 1985).

Scripts are defined as a unique type of knowledge schema (Lord and Kernan, 1987). A schema is a generalized cognitive framework socially constructed by actors to process information and make sense of situations. Schemas primarily deal with the processing of information by individuals. However, scripts are the one schema concept that is primarily concerned with an individual's behavior (Gioia & Poole, 1984). Abelson (1981) refers to scripts as the belief systems that try to understand how actors perceive social reality and how this construction of reality translates into their social behavior. He suggests that in a weak sense 'scripts' are a bundle of inferences about potential future events and in a strong sense it creates expectations about the sequence of events and its current order. He refers to scripts as a psychological reality and explains it with the following story:

John was feeling very hungry as he entered the restaurant. He settled himself at a table and noticed that the waiter was nearby. Suddenly, however, he realized that he'd forgotten his reading glasses (Schank & Abelson cited in Abelson, 1981, p. 715).

It is interesting to understand this analogy here. Even though the menu had not been given to him as yet, he perceived the likely difficulty he would have in reading the menu. This realization that he had forgotten his glasses arose out of an expectation of the series

of events that would occur when he entered the restaurant. Thus, certain activities sometimes do not even require any conscious mental processing (Johnson et al, 1999). In a similar vein, Gioia and Poole (1984) define scripts as “a schematic knowledge structure held in the memory that specifies behavior or event sequences that are appropriate for specific situations” (p.449). They further suggest that these scripts may originate as a result of personal experience or through the process of interpersonal and media communication.

At the heart of a cognitive perspective lies the conviction that people are important.

Bunge & Ardila (1987) define cognition as:

Cognition embraces perception, imagination, language, and conception (including thinking). Cognition is of course the subject matter of cognitive psychology. This discipline, often advertised as the *dernier cri de la mode*, is actually the oldest branch of psychology. Indeed all philosophers, from Socrates to Kant, were more intrigued by cognition theory than by any other mental ability’ (p. 207).

A cognitive perspective endeavors to understand the plethora of emotions of the actors involved in an empathetic way. It appreciates and recognizes the importance of the way various actors perceive and construct social realities. A clear understanding of these perceptions, values and beliefs enables the researcher to get a better understanding of the social processes in the context of the study. Bandura (2001) further explains the social cognitive theory from an “agentic” perspective and suggests that people are both producers and products of social systems. This implies there are patterns of socially interdependent efforts and collective actions that also exert determinative influences.

Social cognition refers to the ways in which people understand and interpret events, and also to those factors that affect this understanding (Bartunek & Moch cited in

Bartunek, Lacey & Wood, 1992). Thus, cognitive beliefs of the actors involved subsequently translate into actions or reactions whereby their understanding of the happenings and expected series of events guide them. Thus the use of script theory is of significant use in trying to understand personality (Demorest & Alexander, 1992). A significant contribution to the cognitive school of thought in a formal way can be traced back to the works of Chester Barnard in 1938 (Nicolini, 1999). The levels of analysis while studying in a cognitive context is important and often misunderstood (Stimpert, 1998). Various researchers have tried to address the problems related to the level of analysis in cognitive studies and explain that cognition may be at an individual level and also at a group level (Ford, 2000).

Literature and works on cognition introduces an array of the types of shared cognition to include shared mental models, social networks, norms, transactive memory and shared information (Mohammed, 2000). It is important to understand the process of collective cognition as also the impact of such collective cognition on work behavior to predict and guide work behavior in groups (Gibson, 2001). Human beings are social creatures and are influenced by their surroundings, as also they influence their surroundings. Moscovici (1988, 1963) uses the term *social representations* as ways of world making. In simpler terms it may be referred to as meanings, beliefs, ideas and values shared by the members of a group. Moscovici (1963) defines social representation as “the elaboration of a social object by the community for the purpose of behaving and communicating” (p. 251). He further highlights that this concept can replace those of image and opinion, which are comparatively static. These images, values, beliefs,

attitudes, opinions and experiences are socially constructed and “confirm the relation between social and cognitive phenomena, communication and thought” (p. 211).

The Russian literary critic Bakhtin refers to representations as: “thought about the world and thought in the world” (Moscovici, 1988, p. 230). Jahoda (1988) argues that social representation is not as distinctive a field as made out to be and says that it is just an extension of related concepts such as culture which has been defined as “symbolic meaning system’ (Rohner cited in Jahoda, 1988, p.200) and what the anthropologists refer to as “folk models” (Holy & Stuchlik cited in Jahoda, 1988, p. 206).

Moscovici (1988) admits that social representation theory has a relation with the field of social cognition. It must be noted that there exists a certain similarity between the concepts of cognition, social representations, beliefs and opinions. The point to be understood here is that social representation theory takes the argument a step further. It explains that there exists a similarity in the patterns of thinking of people in a subgroup who tend to compare, analyze and classify behaviors and thereby objectify them as a part of their social setting. Each person contributes to this shared knowledge and transmits it around his own niche (Moscovici, 1988).

Social representation takes into consideration both the historical experiences and the current social perspectives to understand a phenomenon. Moscovisci (1988) further argues that the understanding of social representations “can lead us to a social psychology of knowledge to compare groups of cultures” (p. 217). In this study it would enable the researcher to gather an understanding of the clash of social representations of the various employee groups. The shared mental model literature suggests that team effectiveness improves when there is a collective orientation and a shared understanding

of goals and the situation and that there exists a need to link such shared mental modes with team outcomes (Mohammed & Dumville, 2001).

Implications of institutional logics on trust. It is essential to define at this point of time the attitudes or values that must be shared and also the outcome of such shared cognition on trust (e.g. Cannon-Bowers and Salas, 2001). Mental scripts are concerned with the norms of appropriate behavior. An acceptance that such behavior is appropriate leads to legitimacy as can be explained by the definition of legitimacy by Suchman (1995):

Legitimacy is a generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definitions (p. 574).

Thus, a belief that the actions of the organization are appropriate and ethical would legitimize the actions of an organization. This legitimacy would in turn give the organization credibility and support of its members. If the direction of the organization is considered legitimate as per the institutional logics of the various institutional actors involved, it is argued that the levels of trust would be considerably impacted. Such institutional logics as discussed earlier are best understood through mental scripts. As discussed earlier, literature also supports shared cognition exists in subgroups (e.g. Moscovici, 1988; Mohammed, 2000) and that different actors in an organization may be driven by different logics (e.g. Scott et al, 1997; Friedland and Alford, 1991). Literature also supports the dynamics of “collective trust” (e.g. Kramer, Brewer & Hanna, 1996)

and the need for low diversity in value-systems in a team in order to be effective (Jehn, Northcraft & Neale, 1999).

Summary

Understanding the dynamics of trust continues to remain an elusive and evasive area of study. The perception of trustworthiness in times of change has social dimensions attached to it. An institutional framework to understand this process of change in conjunction with the traditional theories of trust provides a fresh approach to understand these social intricacies. This approach will eventually lead to a better understanding of the dynamics of trust in the context of change as such values and social characteristics are best explained by institutional logics. These institutional logics are best understood through mental scripts. Mental scripts on the norms of appropriate behavior may vary across the various subgroups within an organization. Such a variance between members in an organization can be explained by the dynamics of shared cognition and social representations.

Chapter Two: Research Methodology

Research Design

A series of 41 interviews conducted between June and July 2000 were analyzed for this study. These interviews were conducted by multiple researchers most of who are faculty in the Faculty of Management at the University of Lethbridge. The informants were employees of the Taber Integrated Primary Care Project and the sample comprised of senior managers, physicians, middle-level managers, nurse-managers, nurses, support staff and social workers. The interviews were semi-structured in nature and were aimed at analyzing changes in the healthcare setup at three levels. The informants were given the list of questions prior to the conduct of the interviews and had sufficient time to ponder over the issues. The three levels at which the questions were directed are Alberta Health, Chinook Health Region and the Taber Project (see Appendix A). The Taber Project is a part of the Chinook Health Region, which in turn is a part of Alberta Health. This study focuses on the responses that were directed to Taber Project in particular.

Students of the university who were paid at an hourly basis subsequently transcribed these interviews. The researcher got access to these interviews and was given permission to analyze them from the organization and the research group at the university. These interviews were undertaken to understand the dynamics of change as a broad theme and did not intend to measure or capture the dynamics of trust in particular. Therefore, it provided an ideal setting and rich data to integrate the theories of trust, institutional theory and social capital in the context of change.

Scott (1995) suggests that the use of both variance and process approaches are justified while trying to understand how institutions work. A variance approach to institutional research attaches primacy to the factors that are causally associated with the phenomena of interest. It seeks to address the question: “Why did the observed event happen?” A process approach on the other hand is influenced by happenings of the past and seeks to understand the occurrence of events and addresses the question: “How did the observed effects happen?” (p. 64-65) Being interpretive in nature and seeking to examine the process of institutional change, a qualitative framework was ideal for the purposes of this study. A qualitative study is often helpful when one seeks to understand the “local meanings of phenomena and the interactions that create such meanings” (Bartunek & Seo, 2002).

This research project was conducted in two phases. The first phase of the study endeavors to empirically measure whether trust emerges as an issue in times of change and if it emerges, it seeks to explore if trust systematically varies across various subgroups in an organization. In the context of this study, the first phase adopts a variance approach as it seeks to identify “what factors were associated” with the phenomena of interest (Scott, 1995, p. 65). The variance approach seeks to identify the factors involved and attempt to establish causal relationships. Hence, the Partial reduction in Loss approach was constructed to analyze these interviews. The details of this framework are explained in the subsequent paragraphs. The second phase of the study seeks to understand the process of these patterns of trust and explore if a clash of institutional logic between the various subgroups impacts such trust in the system. Such a

clash may lead to mistrust in the organization. The results of these two phases of the study will explain the dynamics of trust in an institutional context.

Research Propositions

The two research propositions of this study are as follows:

- (1) ***P1***: Types of trust will vary across subgroups.
- (2) ***P2***: The variance of trust across subgroups can be explained by their differing institutional logics.

Phases of the study

The two research propositions constitute the two phases of the study. Hence:

- (1) Study I: Research proposition I.
- (2) Study II: Research Proposition II.

Methodology for Study I: Partial Reduction in Loss Approach (Rust & Cooil, 1994)

As suggested earlier, the first phase of the study endeavors to determine whether the theme of trust emerges from the interviews. The framework of *ability*, *benevolence* and *integrity* proposed by Mayer et al (1995) on trust was utilized for meeting this requirement. This was done by means of conducting an interrater reliability test. In an interrater reliability test each of the N judges codes each of the M categorical items into one of the K mutually exclusive categories (Rust & Cooil, 1994). In the context of this study the three judges (N1, N2 & N3) coded the three M categorical items namely “ability”, “benevolence” and “integrity” (M1, M2 & M3) into one of the three mutually

exclusive categories “yes”, “somewhat” and “no” (K1, K2 & K3). In simpler terms the independent raters judge the interview on the question: “Did ability (or benevolence or integrity) as a theme impacting trust emerge in the interview?” Thus, different judges are given the same interviews and asked to make a judgment on the presence of these three attributes.

Based on the judgment of the rater-analysts (judges), a degree of agreement is obtained to quantify the rate of agreement using the Proportional Reduction in Loss approach as suggested by Rust & Cooil (1994). A high degree of agreement determines a high degree of reliability. It also gives a quantitative score between 0 and 1 and this score is comparable to Cronbach’s alpha for determining the reliability and internal consistency of the findings. Nunally’s rule of thumb states that a reliability level of .70 for Cronbach’s alpha will suffice and is comparable to a reliability measure of .70 using the Proportional Reduction in Loss approach and this comparison is statistically proven (Rust & Cooil, 1994). The authors further argue that the Proportional Reduction in Loss approach is more statistically robust than the other measures such as “Proportional Agreement”, “Cohen’s k” and “The Perrault and Leigh Measure” as it takes into account factors such as number of categories, number of judges and random agreements.

Methodology for Study II

A preliminary overview of the interviews revealed a certain similarity in the thought-patterns of employees from similar positions and subgroups in the organization. This observation is consistent with the literature on shared cognition (Mohammed, 2000; Gibson, 2001), collective trust (Kramer, Brewer & Hanna, 1996) and social

representation (Moscovici, 1963,1988). Hence the interviews of the various subgroups namely the top management, middle managers, physicians, nurse managers, nurses and support staff were analyzed as separate entities. An endeavor was now made to understand ‘institutional logics’ on norms of appropriate behavior and the impact of such norms and values on trust across subgroups.

Justification of this approach

As this study combines the positivist and interpretive approaches in analyzing the data available in the form of interviews, the findings will demonstrate interpretive validity and reliability. More significantly, the data used in this study was collected to understand the process of change without any bias on the part of the interviewers to understand trust. Issues of validity and reliability have often haunted the domain of qualitative research (Creswell, 1998; Healy & Perry, 2000; Maxwell, 1996; Patton, 2000; Rust & Cooil, 1994; Taylor, 1999; and Walcott, 2001).

This study addresses these limitations of reliability and interpretive validity (e.g. Altheide & Johnson, 1994) and also capitalizes on the strengths of any qualitative inquiry, which significantly benefits from the richness of the data. Such reliability measurement of qualitative data is considered important to determine the stability and quality of the data obtained (Rust & Cooil, 1994). The logical conclusion of Study I will be to understand this variance and interpret the findings. Study II takes on from the findings of Study I and adopts an institutional perspective in understanding issues related to trust and organizational social capital.

Training of Rater-Analysts

Three management graduate students at the University of Lethbridge were selected as the rater-analysts for Study I and paid on an hourly basis. They were trained and given a background of trust to enable them to make a judgment on the interviews. They all shared a common interest in organizational studies but were not experts in the dynamics of trust. Prior to analyzing the interviews all of them signed an agreement of confidentiality.

This training involved individual interaction with the three rater-analysts separately and also a group meeting to come to a joint agreement on the scope and definition of the various terms. The rater-analysts were also given written material in the form of articles to enable them to understand the definition of trust on the framework of trust given by Mayer et al (1995). Hence, this part of the study was devoted to training the raters in determining if trust emerges as a theme in the context of change. It is critical to prove beyond reasonable doubt that trust is indeed important and to try to understand how it manifests itself in the interviews. But trust is a complex phenomenon and pointing out such references to trust may be a difficult task. This ambiguity has been put rather succinctly in the following quote:

Trust...tends to be somewhat like a combination of the weather and motherhood; it is widely talked about, and it is widely assumed to be good for organizations. When it comes to specifying just what it means in an organizational context, however, vagueness creeps in." (Porter, Lawler, & Hackman cited in McAllister, 1995, p. 24).

The question that haunts researchers and practitioners alike is: “What is trust?” Even though we mention this concept of trust often in our day-to-day interactions and refer to its importance, it is quite difficult to classify it in a tangible way. Hence, a clear framework of trust was used for the first phase of the study. This framework as suggested by Mayer et al. (1995) says that trust occurs when the trusting party perceives *ability*, *benevolence* and *integrity* in the organization. Thus, it is argued that if the employee’s perceive these three attributes in the context of change, trust, as a theme would have emerged from the interviews.

It is important to understand at this point that no judgment is to be made on the direction of trust, which implies that, these patterns of trust or distrust are inconsequential at this point of the study. Therefore, the rater-analysts would only be examining if trust as a theme emerges in the interviews. Hence, the unit of analysis is ‘individual’ and the level of analysis is ‘organization’ in this study.

Pilot test

The pilot test comprised of three interviews. It consisted of an interview each of a representative of the top management, a physician and a nurse. The researcher intentionally selected these three interviews from the list. It also enabled the rater-analysts to get a feel of the context of the study. The same three interviews were given to each of the three rater-analysts and in all cases the names and designation of the respondents were hidden. The three rater-analysts coded these interviews separately and individual discussions were held with them at the end of this activity to discuss their ratings with them. As anticipated, the rater-analysts had some difficulties in quantifying

these three attributes initially but were able to clearly point out some references to these attributes. There was also a general agreement on the definition of these attributes and an acceptance that these attributes might overlap on occasions.

The initial questionnaire comprised of three questions. These three questions aimed to examine whether the three attributes of trust namely *ability*, *benevolence* and *integrity* (M1, M2 and M3) emerged in the interviews impacting trust in the context of change. Based on the presence or absence of these attributes, they were to be classified into the three mutually exclusive categories “Yes”, “Somewhat” and “No” (K1, K2 and K3). Thus, the three rater-analysts (Z1, Z2 and Z3) were asked to independently assess the interviews. The rater-analysts expressed some difficulties in answering the three questions, as they tended to compare the three attributes with each other while making their judgment whereas the three questions were to be answered in isolation to each other.

To address this concern, based on the training session and the feedback of the rater-analysts, the researcher constructed a final questionnaire consisting of five questions (see Appendix ‘B’). The fourth question that was added to the questionnaire gave the rater-analysts the freedom to choose as to which attribute impacted trust the most in the context of change. This question would also explain the variance in trust as judged by the rater-analysts. Also a fifth question was added in order to determine the level of confidence of the rater-analysts in their judgments to determine the level of confidence of the rater-analysts.

On individual interaction with the rater-analysts and discussing their responses and coding schemes with them the researcher noticed a very similar pattern of thought across the three rater-analysts. During the discussions the researcher asked the rater-analysts to

pinpoint references to trust across the three variables in the interviews to gather an understanding of whether the variables were well defined or not. These discussions highlighted that the constructs were well defined. There was also a significant agreement in the coding schemes adopted by the three researchers. The researcher was now confident that the rater-analysts were trained adequately in the dynamics of trust to go ahead with the interrater reliability tests. The rater-analysts also felt confident as the training enabled them get better acquainted with the three variables.

Scope and Limitations

The following conditions and issues may have exerted certain limitations on the scope and related aspects of the study:

- (1) The scope of this study is limited to the selected variables of trust, mental scripts and institutional dynamics within the Taber Project.
- (2) This study relies on 41 interviews conducted and transcribed by the Taber Research Team between June and July 2000. These interviews were conducted to understand the process of change and did not seek to specifically inquire into certain issues relating to trust. This is also assumed to be a strength because in case trust emerges as a dominant theme it adds value to the findings.
- (3) The findings of this study are not generalizable as this study seeks to understand a phenomenon in detail.
- (4) It may be difficult to differentiate between trust in the organization as being different from trust in the healthcare sector in Alberta. Thus, there

may be an overlap between organizational trust and trust in the institution in certain instances.

- (5) Dynamics of change are best understood through a longitudinal study. However, this is a cross-sectional study.

Summary

The construct of trust is complex and has been determined by academicians and practitioners alike as a key requirement for organizational social capital. Mayer et al (1995) provide a good framework to understand the dynamics of trust. The Taber Project provides a great microcosm of this environment for study. This study adopts both variance and process approaches towards analyzing the data. Study I examines variance of trust by means of an interrater reliability test. An interrater reliability test adopting the Partial Reduction in Loss approach addresses the issues of reliability and interpretive validity. It also sets the stage for a more interpretive nature of findings. Study II explores the process in greater detail by analyzing the interviews from an interpretive approach. Hence, this study benefits from an integration of both positivist and interpretive approaches to research (Lee, 1991).

Chapter Three: Study I

P1: Types of trust will vary across subgroups

Study I adopted a variance approach. It is important to demonstrate the following so as to test the first proposition:

- (A) The framework provided by Mayer et al (1995) is reliable and valid to operationalize trust.
- (B) Trust is an important issue in times of change.
- (C) However issues that impact such trust, and types of trust vary across the subgroups of an organization.

Inter-Rater Reliability Test

An inter-rater reliability test was conducted for such purposes in this part of the study details of which have been discussed in the previous chapter.

Sample. The sample constituted the balance 38 of 41 interviews. These were analyzed for determining reliability of the instrument on trust that was constructed based on the work of Mayer et al (1995). These interviews were numbered at random from 4 to 41 and the names and designations of the respondents were unknown to the rater-analysts. Each of the 38 interviews was to be judged by any two of the three rater-analysts. Rater-Analyst N1 was given 26 interviews and rater-analyst N2 and N3 were given 25 interviews each. Thus, the researcher prepared a total of 76 questionnaires and these questionnaires were given to the rater-analysts in electronic or paper form as requested by them.

The details of the sample are as given in the table below. The three members of the allied staff comprised of two social workers and one researcher within the organization.

TABLE 1
Demographics of sample

Senior managers	5	13.20%
Physicians	3	7.89%
Middle-level managers	9	23.68%
Nurse-managers	3	7.89%
Nurses	8	21.05%
Support Staff	7	18.42%
Allied Staff	3	17.89%

These interviews along with the questionnaires were given to the three rater-analysts on May 21, 2002. All the rater-analysts returned the completed questionnaires with their judgments by June 3, 2002. The rater-analysts answered all the questions and all the questionnaires were usable for the study. Thus, the usable response rate for the study was 100%. The training of the rater-analysts and the fact that they were graduate students enabled the researcher to get such a high usable response rate.

Results

Proposition P1 (A): Reliability and interpretive validity. The results of the interrater reliability test are as follows:

TABLE 2
Reliability

Attribute	Proportional Reduction In Loss reliability level	Percentage of agreement
Overall Instrument	.78	73.68%
Ability	.83	78.94%
Benevolence	.75	71.05%
Integrity	.75	71.05%

As evidenced by the results, a reliability measure of .78 was obtained for the study across the three attributes. This implies that there is an acceptable level of consistency across raters with their application of trust. Thus the framework used for this study is reliable. The framework of *ability*, *benevolence* and *integrity* is therefore a good way to understand trust and these results support the literature on the subject. It is also important to note that reliability occurred across all the three categories. Reliability was highest for *ability* with a measure of .83; and it was .75 each for *benevolence* and *integrity*. Thus, *ability* appears to be the most easily identifiable and well defined of the three attributes.

Proposition P1 (B): Trust emerges as a theme in times of change. A detailed analysis of the interrater reliability test revealed the following:

- I. Overall number of “Yes” judgments: 84.21% (192/228).
- II. Overall number of “Somewhat” judgments: 14.03% (32/228).
- III. Overall number of “No” judgments: 1.75% (4/228).
- IV. Average level of confidence of the researchers: 6.38 (out of 7).
- V. Rate of partial disagreement *: 23.68% (24/114)
- VI. Rate of complete disagreement **: 2.63% (3/114).

- VII. Rate of agreement on which attribute had the most significant impact on trust: 42.1% (16/38).
- VIII. Overall number of judgments that “ability” impacted trust the most: 50% (38/76).
- IX. Overall number of judgments that “benevolence” impacted trust the most: 26.31% (20/76).
- X. Overall number of judgments that “integrity” impacted trust the most: 23.69% (18/76).

Note: * Partial disagreement implies a difference of one categorical group in the judgment between the two rater-analysts (“Yes” and “Somewhat”, or “Somewhat” and “No”).

** Complete disagreement implies a difference across two categorical groups between the two rater-analysts (“Yes” and “No”).

It is important to appreciate that these dimensions of trust emerged in an overwhelming 84.21% of the judgments. This implies that trust is an essential component in the context of organizational change. An average level of confidence of 6.38 (out of 7) shows that the rater-analysts were very confident with their judgments and attaches significance to the reliability and interpretive validity of the findings. The rate of agreement on the attribute that impacted trust was only 42.1%, which is not particularly high. This is attributable to the fact that in certain cases there is an overlap between the

variables in particular between *ability* and *integrity*. The authors Mayer et al (1995) agree that there maybe an overlap between these three attributes in certain instances.

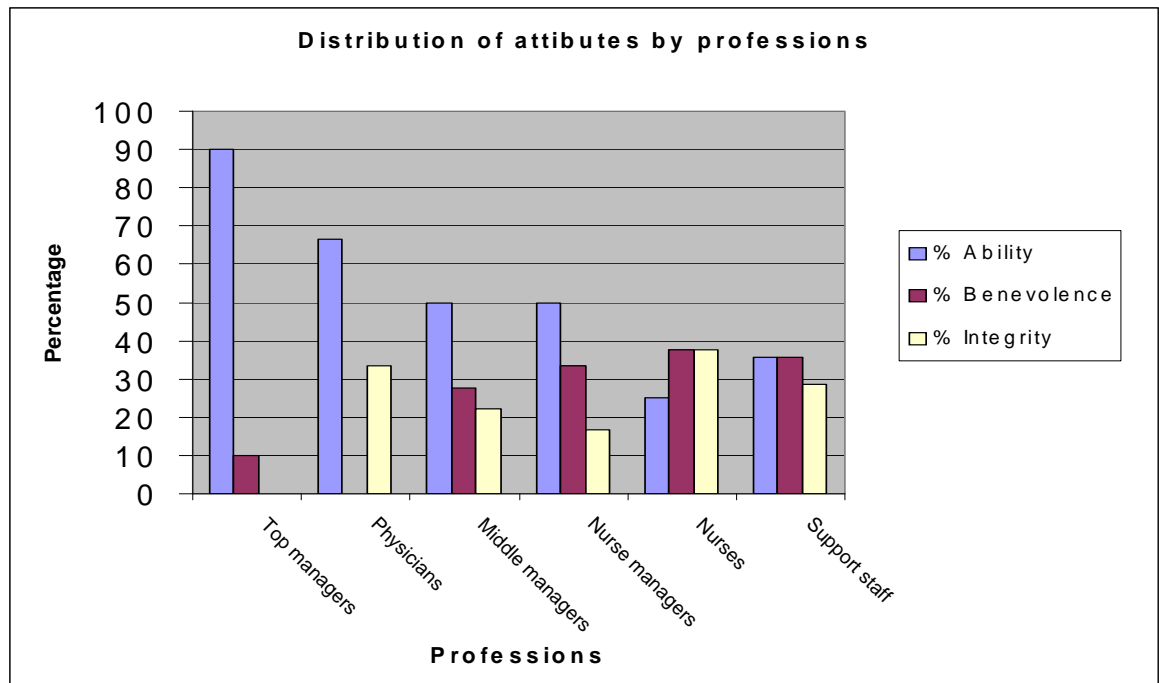
A common difficulty faced by the three rater-analysts was the difficulty in classifying failure of communication or lack of openness in communication. This failure in communication may be seen both as a lack of *ability* of the top management to create an atmosphere conducive for openness, and also creates doubts in the mind of the employees who are prone to suspect the *integrity* of the top management. Rater-analysts N2 and N3 gave justification on each of these judgments and also pinpointed reference to these attributes in the interviews in all their judgments.

These open-ended components of qualitative feedback were also useful for the researcher to understand how the rater-analysts had understood the complex dimensions of trust and were consulted on completion of coding the various interviews in the next phase of the study. The fact that “trust” overwhelmingly emerged as a theme in the context of this institutional change and that this framework to examine trust was reliable and internally consistent provided an excellent launching pad to enter the interpretive portion of the study and examine the mental scripts of the constituents involved.

Proposition P1 (C): Types of trust vary across subgroups. The researcher was now interested in exploring which of the three attributes impacted this trust the most and whether any shared representation existed across the subgroups based on professional affiliations. This requirement was fulfilled by the fourth question of the questionnaire: “According to you which attribute impacted trust the most in this interview?” The rater-analysts therefore had the flexibility to rate the most important attribute of trust. A

frequency count of attributes rated as most important to the various professional groups showed that there is quite a difference in the issues that would impact trust. It is also interesting to note how the importance of ability kept reducing down the hierarchical order and how the values of benevolence and integrity were particularly important to the nurses and the support staff. For the balance of the study the three interviews of the associated staff such as social workers and researchers with the organization would not be analyzed due to the unique and varying nature of their duties. Hence, the analysis of the rest of the study on concentrated on the 35 of 38 interviews of the six subgroups discussed in the following paragraphs.

FIGURE 1



- (1) *Top Management:* As explained earlier, each interview was analyzed separately by any two of the three rater-analysts. A total of five interviews of top managers were analyzed. As two rater-analysts analyzed each

- (2) *Physicians:* The physicians on the other hand are driven by both the *ability* and *integrity* of the system in their feelings of trust in the system with 66.67% of the judgments rating *ability* and 33.33% of the judgments highlighting the *integrity* dynamics of trust.
- (3) *Middle managers:* 50% of the judgments rated *ability*, 27.78% rated *benevolence* and 22.22% rated *integrity* as the key factor influencing trust.
- (4) *Nurse managers:* 50% of the judgments rated *ability*, 33.34% of the judgments rated *benevolence* and 16.67% of the judgments rated *integrity* as the attribute that impacted trust the most in the interviews of the nurse managers.
- (5) *Nurses:* 25% of the judgments rated *ability*, 37.5% of the judgments rated *benevolence* and 37.5% of the judgments rated *integrity* as the attribute that impacted trust the most in the interviews of the nurses. The high importance attached to acts of kindness and compassion and to the honesty of the system is quite different from the other subgroups as discussed previously.

- (6) *Support staff*: 35.71% of the judgments rated *ability*, 35.71% of the judgments rated *benevolence* and 28.57% of the judgments rated *integrity* as the attribute that impacted trust the most in the interviews of the support staff.

Proposition P1 (C): Statistical analysis of these differences between subgroups. A series of chi square tests were run to examine if any significant difference existed across subgroups based on the attribute that impacted trust the most in the interviews. As a chi-square test is a non-parametric test, it was utilized for this study. The first set of chi-square tests was run across all the six subgroups of the organization. The results suggested that there is a significant difference in the perceptions of trust of the respondents across the attribute of ability at the $p \leq .05$ level (where $p = .035$). Hence, it can be safely argued that the subgroup one belongs to has a significant impact on the ability dimension of trust.

Another series of chi-square tests was run classifying the six subgroups into three major groups based on their perceived status and position in the organization by the researcher. The first group comprised of the top managers and the physicians who were considered to be the *institutional entrepreneurs* (e.g. Di Maggio in Scott, 1995, p. 72). The second group comprising of the middle-level managers and the nurse-managers are considered to be *implementers* (e.g. Peters & Waterman, 1982, p. 53). Unlike the institutional entrepreneurs they do not have the resources or authority. The third group comprising of nurses and the support staff is being referred to as the *change followers* and is at the lower end of the hierarchy.

A chi-square test was run across these three groups i.e. the institutional entrepreneurs, implementers and change followers. This revealed a significant difference on the dynamics of *ability* at the $p \leq .01$ level (where $p = .006$). This is similar to the results of the first set of chi-square tests which also suggest that the position of an individual in the organization would make a significant difference on their propensity to be influenced in their feelings of trust related with *ability*.

Another series of chi square tests was run between the “institutional entrepreneurs” and “change followers”. This series of tests revealed a significant difference of *ability* at the $p \leq .001$ level (where $p = .001$). The test also revealed a significant difference across the attribute *benevolence* at the $p \leq .05$ level (where $p = .016$). Thus there is a significant difference between the “institutional entrepreneurs” and the “change followers” on the attributes of both *ability* and *benevolence*.

It is therefore argued that these differences appear to be occurring across professional affiliations with the people at the top of the hierarchy attaching greater significance to the dimensions of *ability* in their propensity to trust the system. Conversely, the staff at the lower end of the hierarchy (i.e. the change followers) seems to attach more importance to the dynamics of *benevolence* as opposed to the institutional entrepreneurs. However, there is no significant difference between subgroups or the created groups on the *integrity* related dynamics of trust.

Direction for Study II

The findings of Study I suggest that certain patterns of shared cognition of trust exist in subgroups with *ability* being the most clearly defined attribute. Such shared

cognition is consistent with the literature in the field of collective trust (Kramer et al., 1996), shared cognition (Mohammed, 2000; Gibson, 2001) and social representation (Moscovici, 1988, 1963). However, no attempt as yet has been made in the study to understand the direction of trust. Hence, at this point of time there exist no details on whether the employees repose trust or alternately mistrust the organization in these times of change. Study I is also limited in its understanding of institutional dynamics as none of the three attributes addresses the issues of values and norms of appropriate behavior directly or categorically.

Also, the attribute *ability* is a fairly broad construct as it encompasses the concepts of *business-sense*, *judgment* and *competence*. Study I was helpful to understand such patterns of variance across the attributes of but it does not explain the causes of such variance. There is also reason to believe that there are some additional dynamics such as institutional logics that better explain such variance in trust across subgroups and groups. Study II is therefore a logical conclusion to Study I, as it will endeavor to delve into the process to understand the phenomena.

Summary

The framework provided by Mayer et al (1995) on trust is reliable and valid to understand the dynamics of trust. Such reliability demonstrates that the constructs of *ability*, *benevolence* and *integrity* are clearly defined and the instrument measures what it intends to measure. Trust emerges as a predominant and identifiable theme in times of change even without any intention of the researchers to explore such feelings. There exists a significant difference in the impact of attributes of *ability* and *benevolence*

related dynamics between the “institutional entrepreneurs” (top managers and physicians) and the “change followers” (nurses and support staff). However, there is no significant difference amongst groups on the attribute of *integrity* related dimensions of trust. Hence, the first proposition that trust will vary across subgroups is supported by the findings

Chapter Four: Study II

P2: The variance of trust across subgroups can be explained by their differing institutional logics

As discussed in the methodology section, Study II seeks to understand the process and phenomena in greater detail. The central arguments behind this proposition are:

- (A) Different subgroups in an organization have different institutional logics on norms of appropriate behavior.
- (B) This clash of institutional logics or mental scripts leads to mistrust.
- (C) These dynamics of trust change with the different institutional logics.

Sample

The sample constituted 38 of the 41 interviews that were conducted by the Taber research team at the University of Lethbridge. These 41 interviews included the three interviews that were a part of the pilot study and the 38 interviews that were used for the interrater reliability test. The sample comprised of the top management, middle managers, physicians, nurse managers, support staff and nurses. The three interviews of the allied staff were omitted from the analysis for reasons as discussed previously.

Differences in Institutional Logics

The dynamics of trust as explained by the findings of Study I highlights that there exists collective trust, shared cognition or social representation between members of

various subgroups. This study argues that dynamics of trust are best understood in an institutional context and explained by an institutional framework. To quote Scott (1987):

Institutional frameworks define the ends and shape the means by which interests are determined and pursued. Institutional factors determine that actors in one type of setting, called firms, pursue profits; that actors in another setting, called agencies, seek larger budgets; that actors in a third setting, called political parties, seek votes; and that actors in even a stranger setting, research universities, pursue publications (p. 508).

Hence, there exist different issues and norms of appropriate behavior for different settings. This study only explores one such research setting, that of the healthcare organization at Taber. Yet it argues that even within the same research setting there exist differing institutional logics. In this chapter I will explain how a clash of *managerial or corporate logic* and *logics of empathy and benevolence* between various subgroups impacts trust.

Mental scripts of the top management. Efficiency and rationality overwhelmingly influence the top management. They operate on managerial or corporate logics. A top manager remarked:

I think it'll save dollars, is what a part of the direction is. Now, does that really say that we are going to spend less money, probably not, but what it really means is we'll have more money for more services, is what it really amounts to. So if you can do and look after the individual better under this system, then the resulting fact is that you can do more with the same amount of dollars you have, and I think that's the overriding, is to be effective and efficient.

This quote is representative of the top management. Top managers believe that as the doctors are now involved in a leadership role and have incentives to control costs, the

system would see lesser wastage and a better utilization of resources. Their scripts dictate that a healthcare organization should be run in a professional, integrated manner and cost-effective manner. Thus, the appropriate behavior for them is driven by rationality. Their trust in this process of change is significantly high as it addresses these issues of effectiveness and efficiency. Statements that emphasized the need for exploring “service delivery costs” and “how smart you can get when you have fiscal restraint” highlight such *managerial or corporate logics*. These logics are consistent with the interrater reliability test findings, which suggest that the attribute *ability* was pivotal to their feelings of trust. This is evident from the rater-analysts judging in 90% of the cases that the top-management is most influenced by the *ability* dynamics of trust.

A closer look at this propensity to be influenced by *ability* reveals that “business-sense” is key to their trust in the organization. “Business sense” is one of the three facets of *ability* (Mayer et al, 1995). Hence, they trust the new system as it makes “business sense” to them and is consistent with their *managerial or corporate logics*. Thus, there is congruence between their values and the current organizational objectives. This finding also suggests that dynamics of trust are better understood in an institutional context, as it is able to address the limitations of traditional theories on trust.

Mental scripts of physicians. The physicians are also driven by *managerial or corporate logics*. Their norms of rationality dictate the need to provide these services “in a better way.” They feel that this system would enable them to “practice medicine differently.” They believe that an efficient delivery of these services would enhance satisfaction and address the more important issues of “prevention” and “wellness” that

were currently ignored. Their norms of rationality differ slightly from those of the top management as their mental scripts address the process of healthcare delivery as being the key issue. Unlike the past, this new system of healthcare delivery gives them the leadership role and makes their role integral to managing the health of the community.

Remarked one of the physicians:

Let's get involved; let's make one of the changes before they are foisted upon us. We've seen the government do a few things to physicians to give us an idea of what their power was and they were unilateral and as a group of physicians we did not like that.

This statement suggests that the physicians are striving to be the institutional entrepreneurs in this process of change. Also, literature supports this new dimension of a physician as a "worker" and not merely as a professional or caregiver who is an active agent negotiating his existence (Hoff, 2001). Their important position in the healthcare setup and the acute shortage of physicians in Alberta made them believe that they could negotiate for a system of healthcare delivery which they believe is in their best interests.

The physicians felt that they were an integral part of the healthcare setup and that this change would give them the flexibility and opportunity to spend more time on prevention, education and other important tasks. They believe that they could now delegate some of their tasks and would not be driven by the necessity to see the "whites of the eyes" in order to be paid under the new Alternate Payment Plan system. Hence, unlike the previous system where their payment was dependent upon the number of patients they had to physically examine, the new system put them on a fixed pay with certain incentives. It also gave them better control over their personal lives. Such beliefs are consistent with the "rational choice model", which suggests that people try to

maximize their gains and minimize their losses in any interaction (Tyler & Kramer, 1996). Such acts are also consistent with literature on “self-interested behavior of agents” (e.g. Hendry, 2002, p. 98).

Study I suggested that *ability* was the most important attribute impacting trust in the physicians. However, in their case this ability was impacted both by “business-sense” and “competence.” This “business-sense” is consistent with *managerial or corporate logics*, as with the top managers. However, the importance they attached to “competence” is explained by their trust in their ability to assume the leadership role. Therefore they also believe that this “judgment” of the organization reposing faith in their capabilities is justified. These findings are consistent with the judgments made by the rater-analysts in Study I, which suggest that the primary factor for trustworthiness in physicians is *ability* (67%). The balance of judgments was made on *integrity* (33%). A closer look on the *integrity* dynamic reveals that the physicians are at pains to justify their institutional entrepreneur role. They argue that they are “not looking to work less” and feel that this approach to “practice medicine differently” with them in the leadership role is appropriate.

Mental scripts of middle-level managers and nurse manager. The middle-level managers and nurse managers are influenced by both the managerial or corporate logics and logics of empathy and benevolence. Their managerial or corporate logics dictate the need to “offer better service through integration as opposed to better service through added dollars” (a middle-level manager) and “justifiable admissions” (a nurse manager). Their logics of empathy and benevolence dictate the need for “community input” (a nurse

manager) and “social justice policy” and “customer service orientation” (a middle-level manager) in addition to norms of efficiency and rationality. Their expectation from the system is a fair balance between empathy and efficiency and this facet is supported by the findings of Study I, which shows a fair balance between the importance of the three attributes of ability, benevolence and integrity.

The middle-level managers also express concern over the need for a better system of communication, feedback and empowerment. They speak of the need to “get people involved” and create an atmosphere conducive for more interaction and understanding amongst the various members. The appropriate behavior for the middle-level managers therefore is a holistic mix of efficiency, patient care and strong networks of communication within the organization. As one of the middle-level managers commented:

You don't do it by saying look I'm not here to make your coffee, you do it by building trust and all sort of other things...So the nurses have to be reasonably flexible and strong and the physicians have to be fairly accepting of the nursing role and accept them as partners in the practice.

Their mental scripts dictate that such change can be implemented successfully only if the members of the organization trusted one another. They were at pains to express their exasperation with the difficulties of the process of change. The references to “more communication is going to be needed” (a middle-level manager), communication being “fairly regimented, fairly top-down” (a middle-level manager) and “communication is the key” (a nurse-manager) are the hallmarks of their interviews.

Their beliefs on the appropriate goals of healthcare vary and it is not possible to generalize the dominance of any institutional logic in particular. The results of Study I suggest that both middle-level managers and nurse-managers are most influenced by the attribute *ability* in only 50% of the judgments, as opposed to 90% of top managers and 66.67% of physicians. However, 33.34% judgments on nurse-managers and 27.78% on middle-level managers attribute *benevolence* as being the key trust factor. Overall, this balance between *managerial or corporate logics* and *logics of empathy and benevolence* in the middle-level managers and nurse-managers is consistent with the findings of trust that were revealed in Study I.

Mental scripts of the nurses. A nurse expressed herself rather passionately, “I went in to nursing because I, want to care for people.” Another remarked that her perception of effectiveness was if she “can see that the patient has improved.” Being nurses, they saw themselves as “the advocates for the people.” These logics of empathy and benevolence are the benchmarks of their mental scripts. To them the key stated issue is ensuring that the quality of care and upholding the ethos of the Canada Health Act are fundamental to any initiatives and they do not perceive this happening.

The healthcare initiatives being taken in Canada to them were inappropriate as these were dictated primarily by economics. Taking a dig at the concept of “Wellness Model” one of them suggested that the drive for reducing hospital admissions might reduce the hospital expenses but that was not a valid criterion for evaluating the wellness of the population. Their distrust in the system therefore stemmed from their belief that these *managerial or corporate logics* were the driving force behind these changes.

In the context of the change taking place in the organization, the appropriate behavior to them was again violated as they were not happy with how they “are being treated” and that “nobody listens” to them. They felt that their input if ever taken meant a “hill of beans” to the management and that they were never given an opportunity to be a part of the decision-making process. Overall the dynamics of trust and appropriate behavior in the context of healthcare were violated and can be understood by this statement:

And it would be nice you know if you had the confidence that this project was to compliment, to actually do what they are willing to do to improve the delivery of care. But I don't think that this is the ultimate goal here.

These frustrations and mistrust expressed by the nurses were a result of a violation of their norms of appropriate behavior, which strongly centered on the values of kindness, tenderness and concern for the patients. Poor communication on behalf of the management also aided such mistrust. These findings are again consistent with the findings of Study I in which 37.5% judgments each are given on the *benevolence* and *integrity* attribute of trust as suggested by the rater-analysts. Thus, their mistrust in the organization stemmed from the violation of *logics of empathy and benevolence* and from their belief that the *integrity* of the organization was suspect.

Mental scripts of the support staff. Engulfed by a myriad of emotions that were similar to the nurses, the support staff again expressed serious doubts on the motives of the organization in general and the healthcare sector in Canada in particular. Remarkd one of them on the healthcare system: “Well I used to think it was great but now I feel

like the vultures are setting in trying to pick or health system apart.” These fears of privatization of health services made them see the changes as a veiled attempt that aimed at dismantling the Canada Health Act. These references that a “two-tier” healthcare was on the anvil were inappropriate according to them.

The appropriate behavior to the support staff was that the Albertans “get the care and they can afford it.” To them the *logics of empathy and benevolence* were the appropriate behavior and they did not perceive it in these changes. The changes violated their system of values and beliefs and this violation as per them made them mistrust both the *integrity* and *benevolence* of the organization. These findings are supported by Study I and also by literature of social capital and trust relating to values of morality (e.g. Durkheim) and integrity (e.g. Becker, 1998; Simons, 1999; Mayer et al, 1995).

Common themes with different logics

An analysis of the interviews also revealed certain commonalties in the themes that existed across the various subgroups. It is essential to understand at this point of time that even though organizational members of different subgroups express similar views on a phenomenon (e.g. their mistrust in the government) they are guided by different logics on such phenomenon. These conflicting logics and mental scripts in relation to trust are discussed in the paragraphs below.

Mistrust in the government: Impact on organizational trust. There was a virtual unanimity across all the subgroups that the government was largely responsible for the crisis in healthcare that exists in Canada. The comments varied from referring to

politicians as “people that talk from one side of their mouth” (a top manager) and “paying lip service to increasing attention to healthcare outcomes” (a middle-level manager). The lack of trust in the government varied from employees referring to politicians as “economic and self-serving” (a nurse) to others who felt that there was “plain stupid government spending on everything under the sun, except for healthcare and education” (a top manager). They also referred to “political interference” (a middle manager), governments having “ulterior motives” (a nurse manager) and felt that “there isn’t good long-term planning” (a physician). A rather passionate statement made by one of the members of the support staff was:

If you have the money you can buy your way in, or, like the politicians were doing, if you have the right connections you can get your uncle seen way ahead of. That’s life, but I don’t like that idea that the little people might kind of get left over with the idea the ones that can will, and those that can’t...(won’t).

This mistrust in the government as expressed by a member of the support staff shows her apprehension that a two-tier healthcare system was on the anvil. The government according to her was not acting in the best interests of the “little people” and was violating her norms of appropriate behavior. The norms of appropriate behavior for her were *logics of empathy and benevolence*. A person from the nursing fraternity expressed concerns about the “ulterior motives of the government” and another suggested, “the government of Alberta was trying to get out of the business of healthcare.” The words used for the project by nursing staff and the support staff revolved around their mistrust using terms such as “hidden agenda”, “a money saving

issue” and another expressing apprehension as she was “suspicious of some of the changes that are being made.”

Such feelings expressed by the nurses and the support staff also highlights the *integrity* dimensions of trust. Such *integrity* related issues of mistrust in the government by the “change followers” were embedded in their mistrust in the organization, which they saw as an extension of the government. The above statement also recognizes the role of “values” on feelings of trust and is consistent with the literature (e.g. Sitkin & Stickel, 1996; Jones & George, 1998).

It is important to appreciate at this point of time that both the *integrity* and *ability* of the government with regards to the healthcare sector were mistrusted to a fairly large extent. The *ability* of the governments came under cloud in particular among the higher echelons. This implies that the institutional logics and norms of appropriate behavior varied across the subgroups. Thereby, this mistrust and antipathy against the government occurred due to different reasons. These findings are consistent with Study I, which reveals that one’s position in the organization has a direct relationship with the importance one attaches to the *ability* attributes of trust. In this case, the managers and physicians do not trust the “competence” dynamics of *ability* of the government.

Integration of services as appropriate behavior. A majority of the respondents felt that the integration of services would be in the best interests of the consumers. There was an understanding and appreciation of the fact that providing services under one roof would provide substantive benefits to the community at Taber. As such there is an agreement that this would avoid a “repetition of service” (a nurse manager), “better serve

the client” (a nurse manager), provide “integration and the seamless delivery of services” (a nurse) and perhaps the intention was to “simplify things for the patients” (support staff). People appreciate that agencies that normally did not work together were now being brought together to provide better and a more efficient service. A physician described this project as being “a good thing both clinically and administratively.” By and large there was unanimity that this integration would benefit the patients. Another dimension of integration was a recognition that there would be a greater “interaction between professionals” (a middle-level manager) and would “improve communication” (a physician) between the various healthcare providers. There was also recognition that the management had taken pains to communicate these aspects of integration through the Project Manager.

It is pertinent to note at this point that one of the primary objectives of the Taber Project is the integration of services. If such an integration of services is appropriate behavior across all subgroups a pertinent question strikes the mind is: “Why should there be different institutional logics or mistrust if most members of the organization believe that the end result of the structural change leading to integration is appropriate?” Such complexities and contradictions indeed make the operationalization of trust complex.

The positive views of the nurses on integration of services as discussed earlier in this section are paradoxical. At one end they believe that integration of services will benefit the patient and at the other end they are opposed to these organizational changes at Taber. These expressed *logics of empathy and benevolence* by the nurses must therefore not be merely taken at face value (nurses as “intuitive auditors” e.g. Kramer, 1996). The nurses perceive these changes being detrimental to their self-interests. Hence,

their use of the metaphor “advocates for the people” is perhaps only partially true as they are also advocating for their perceived reduced status in the new arrangement. I argue that the nurses are using the *logics of empathy and benevolence* as a mere veil. Thus, even if the process of change is appropriate in terms of “value commitments” (e.g. integration being beneficial to the patient), it does not necessarily create trust as if it defies norms of the *rational choice model* (e.g. Tyler & Kramer, 1996) that explains the “self-interested behavior of agents” (e.g. Hendry, 2002). These findings are again consistent with literature, which suggests that “interests and value commitments” are central to the process of change (e.g. Greenwood & Hinings, 1996, p. 1033).

Views on organizational change. One of the top managers suggested that “if you can’t convince the people then it’s really hard to make the changes.” A middle-level manager remarked that bringing about such an attitudinal change would be “really frustrating” as people might be “cynical.” A member from the support staff used the term “turmoil” to describe the Taber Project. The frequencies of change in the healthcare setup in Alberta have been rather alarming particularly since the mid 90’s. The last time such a profound change had occurred was during the regionalization of the health services in Alberta and the dissolution of the erstwhile hospital-boards. The period of change after regionalization was followed by a large number of job losses and a fresh approach to healthcare.

Thus, the past experiences created a sense of mistrust in the minds of some of the employees who were already embittered by it. Such feelings of mistrust and apprehension are consistent with the “knowledge-based trust” (Lewicki & Bunker, 1996) based on the

history of previous interactions, “trust as a transactional phenomena” (Worchel in Lewicki & Bunker, 1996) and the catastrophic quality of mistrust (Burt & Knez, 1996) that occurred due to just one event, namely ‘regionalization’. These needs of trust in times of change are also consistent with literature (e.g. Rousseau et al, 1998; Tyler & Degoey, 1996). It also highlights the unwillingness of the participants to expose themselves to the risks associated with change (e.g. Sheppard & Sherman, 1998).

A nurse manager referred to the computerization drive of services as a good thing but felt that “sometimes it’s hard to teach old dogs new tricks” thereby referring to the difficulties faced in changing mental scripts. A nurse expressed her annoyance on the “state of constant flux” due to these regular changes and felt that in order for these changes to be successful there was a need to “change attitudes.” This change in attitudes as proposed by the nurse implies the need for a change in the ways of looking at the world and the need for a different set of institutional logics and mental scripts to adapt to the new changes. A physician expressed his concern that “change can be stopped by critical mass” thereby acknowledging the difficulties they were facing in implementing such change. These discussions tend to suggest that trust must be treated as both a transactional and an institutional phenomenon.

Role of physician. There was an acceptance across the organization that these changes were “definitely geared and directed by physicians” (a nurse) and that “physicians are key” (a middle-level manager). A physician referred to this drive as allowing “the physicians to manage community resources” and that they now had a “very key role”. One of the senior managers remarked that the idea was to “give the physicians

the responsibility in the system” and give them incentives. There was also recognition across the various subgroups that it would make the physicians assume the “leadership role” (a nurse). Thereby, it is logical to suggest that the physicians are the institutional entrepreneurs in these times of change. Incidentally this situation provides an excellent setting to understand the divergent impact on trust across subgroups.

Literature supports the role of rational choice and power relationships as having an impact on trust (Tyler & Kramer, 1996). A middle-level manager explains this tension in the following manner:

There’s always tension between the nurses and the doctors. It’s, I don’t know whether it’s when they go to school they teach them to do that...the doctors perceive the nurses as some, you know, they’re (there) to facilitate them and the patients and to, to assist. And the nurses, again partially because of the union mentality see themselves as slightly different.

This clash in power relationships between nurses and physicians is intrinsic to their thought process even without a change process and it gets accentuated in times of change. In this case the physicians seek to maximize their status and these change initiatives give them greater authority in the new system. They are therefore inclined to trust the system. The nurses on the other hand feel threatened by the new authority made available to the physicians, as it would imply some of them working under the physicians in the clinic. They are therefore prone to resist this move as it undermines their status. There were a significant number of statements expressing distrust in one or the other professional affiliations with one of the managers referring to nurses as being “control freaks” and as a group who are “not always taught to be critical thinkers.”

Both the top and middle-level managers trust this physician driven initiative, as they believe that this process of change makes “business-sense” (e.g. *ability* in Mayer et al, 1995). They believe that the system can be efficient only if the physicians are in the leadership role and are given incentives to reduce costs and improve the efficiency of the organization. Such “business-sense” is consistent with the *managerial or corporate logics* of institutional literature (Scott et al, 1997) that is dictated by norms of efficiency. It appears only obvious and rational to the managerial staff to give the physicians the leadership role. This project also makes perfect sense to the managerial staff, as the new payment plan would provide the physicians with the right incentives to reduce wastefulness and engage themselves more purposefully in the tasks at hand.

Institutional contradiction: Clash of mental scripts

The above findings suggest that shared cognition exists within the various subgroups. This shared cognition stems from the institutional logics that dictate norms of appropriate behavior for the constituents involved and perceived gains or losses. In the context of this study, the findings suggest that the predominant conflict seems to exist between *managerial or corporate logics* and *logics of empathy and benevolence*. Such a clash between subgroups that appear to be driven by different goals and value systems may be defined as an “institutional contradiction” (Friedland & Alford, 1991).

The higher echelons of power are driven by *managerial or corporate logics*. They recognize the limitations posed by finances, and believe that putting the physicians in the leadership role is one such means to deliver healthcare in a more efficient manner. This makes “business-sense” to them. As the top management and the physicians are driven by

the *managerial or corporate logics* their feelings of trust are best explained by the dynamics of *ability*. Thereby, their propensity to trust the current process of change is best explained on their perceptions that the system has both the “competence” and “business-sense” to undergo this process of change. The physician’s norms of trust are also aided by the rational choice model, which suggests that actors in any interaction tend to maximize their personal gains (e.g. Tyler & Kramer, 1996) and the “self-interested behavior of agents” (e.g. Hendry, 2002). In this case their assumed power and position in the system as also the benefits from the Alternate Payment Plan on their quality of life dictates such behavior and beliefs.

The middle-level managers and nurse managers appear to have a fairly balanced overview of these current changes and their norms of appropriate behavior dictate both *managerial and corporate logics* and *logics of empathy and benevolence*. A new dimension of trust and appropriate behavior arises in their interviews, which revolves around the norms of open and effective communication within the organization. The top managers or the physicians did not particularly address this concern, as this process of change was a top-down one. Everyone acknowledged the only form of communication being the one through the Project Manager. I argue that as it was a trust issue for change, the role of good communication is imperative if this change process is to be successful.

The nurses on the other hand are predominantly influenced by the *logics of empathy and benevolence* and believe that quality of care would be the appropriate behavior for any further movement towards such institutional change. Thereby, the nurses would be willing to trust if they perceived that the organization was acting with compassion and kindness and not merely being driven by an economic motive. Such feelings are

consistent with the definition of *benevolence* as highlighted by Mayer et al. (1995). However, there is an inadequacy in understanding the paradox of this integration being good for patients and yet the process being bad. As explained earlier, the nurses feared a loss of status and felt the need to minimize such personal losses from this process of change. Taking a contrary stance on the relationship between institutional logics and trust, it can be argued in this case that these *logics of empathy and benevolence* are incomplete without the “rational choice theory” of trust.

The support staff expressed their distrust in the current initiatives, as these initiatives were not open or reliable in light of the recent drives towards privatization of health services. This lack of openness and concerns with the perceived reliability of the other party is consistent with the framework of trust (e.g. Mishra, 1996). Their norms of appropriate behavior dictated *logics of empathy and benevolence* and also “norms of equal access to healthcare” as being the driving forces for any healthcare initiatives. As they perceive the current initiatives being driven predominantly by *managerial or corporate logics*, they are concerned that these forces are the part of a larger hidden conspiracy that would eventually violate equal access of health services to the society.

Summary

Institutional logics and traditional frameworks of trust in isolation of each other do not offer adequate means to understand the complex dynamics of trust. The traditional theories on trust do not address the issue of trust being institutionally bound. The findings of this study suggest that different institutional logics relate to different norms of legitimate or appropriate behavior within organizations. These norms of appropriate

behavior also impact trust. Different subgroups in an organization have different institutional logics on norms of appropriate behavior. Such a clash of mental scripts leads to mistrust. These dynamics of trust change with the different meaning systems.

Managerial or corporate logics driven by values of rationality and efficiency, and *logics of empathy and benevolence* driven by values of compassion and care giving are the two clashing logics in this study. These clashes occur in varying degrees and to varying consequences between the various subgroups. The norms of appropriate behavior are again inadequate to inspire trust if an individual perceives any loss of status.

Chapter Five: Discussions and Conclusions

This study operationalized trust at the organizational level by adopting a fairly unique methodology in the use of an interrater reliability test. It subsequently substantiated this variance across subgroups by adopting an institutional perspective. This proved to be extremely valuable and insightful, as it was able to explain the intricacies of the complex and multi-dimensional phenomena of trust. This study also explains how the different subgroups in an organization are driven by differing institutional logics. Such differences in logics have an impact on trust.

Leana & Buren (1999) suggest that organizational social capital is attained through the collective goal orientation and shared trust. There exists a certain degree of interconnectedness within similar groups but there is a clash between subgroups in varying degrees. In order for these changes in the healthcare system to be successful, the system should be acknowledged as fair and legitimate to be considered trustworthy by the organization. This legitimacy may have its roots in the pragmatic, moral or cognitive (Suchman, 1995). Such “pragmatic” norms of legitimacy (e.g. Suchman, 1995, p. 578) are consistent with the “rational choice model” (e.g. Tyler & Kramer, 1996). It is therefore argued that the emphasis of institutional theory on norms of legitimacy is also applicable to the operationalization of the construct of trust.

These differences in institutional logics appear to be more pronounced between the institutional entrepreneurs (top management and physicians) and the change followers (nurses and the support staff). These differences are also consistent with Study I, which suggests that there is a significant difference between these two groups on the attributes

of *ability* at the $p \leq .001$ level, and *benevolence* at the $p \leq .05$ level on the framework of trust provided by Mayer et al (1995). The inappropriateness of the perceived *managerial or corporate logics* by the change followers creates mistrust in their minds. This mistrust manifests itself in the 37.5% and 28.57% judgments of the interviews of the nurses and support staff, suggesting that the *integrity* dynamics of trust were most important to them. They suspected that the stated and implied objectives for change were different. The implementers (middle-level managers and nurse managers) have a fairly balanced view and only the dynamics of *ability* significantly differ across the three groups' i.e. institutional entrepreneurs, implementers and change followers at the $p \leq .01$ level. As such differences are most profound between the institutional entrepreneurs and the change followers; I will primarily focus on them.

As explained earlier, the three sub-attributes of *ability* as suggested by Mayer et al (1995) are “business-sense”, “competence” and “judgment”. Analyzing this argument suggests that even the institutional entrepreneurs (top managers and physicians) have different reasons for being influenced by the *ability* dynamics of trust. The top managers think it makes perfect “business-sense” while the physicians believe that they have the “competence” to be the leaders in this process of change. The *ability* dynamics of trust as evidenced by the nurses (25% judgments) and the support staff (35.71% judgments) however portray slightly differing causes. These two subgroups are most concerned with the “judgment” dynamics of ability. In simpler terms, even though *ability* is a fairly important issue to them, their mistrust in the system actually stems from their belief that the organization is flawed and incorrect in its judgment of driving healthcare by *managerial or corporate logics*. They do not attach much importance to the “business-

sense” dynamics of the top managers or alternately the “competence” dynamics of the physicians.

The logics of the change followers dictated *logics of empathy and benevolence* unlike the *managerial or corporate logics* of the institutional entrepreneurs. It is extremely important to appreciate that this mistrust in the “judgment” of the organizational leadership as evidenced in this study, is better understood through the institutional context of trust by using the analogy of institutional logics as suggested above. It is therefore pertinent to argue that any dissimilarity in institutional logics can lead to mistrust. Alternately, the perceived appropriateness of such logics would lead to trust in the organizational members.

Another important dimension of trust that emerged in this study was the influence of the “rational choice model” (e.g. Tyler & Kramer, 1996) and the “self-interested behavior of agents” (e.g. Hendry, 2002) on the dynamics of trust in which the various institutional actors try to maximize their gains and minimize their personal losses. The nurses perceived a loss of status in the new system and hence it created mistrust in their minds. The physicians on the other hand perceived a better quality of life and greater authority in this new system and hence trusted the new system. The dynamics of trust are therefore mired in complexity and influenced by a large number of independent forces.

There is also reason to believe that internal contradictions exist within the mental scripts of the various institutional actors. To give an example, the nurses believe that the integration of services would benefit the patients and the community. They also consider themselves as the advocates for the people. However, they argue that the changes being implemented are a part of a larger conspiracy to deny people adequate healthcare

facilities. This contradiction at the face value does not make much sense. A closer introspection explains that the nurses are advocating such *logics of empathy and benevolence* to disguise their perceived loss of status. The support staff remembers the job losses that occurred during the last major organizational change of regionalization and they fear that the current changes may also have an impact on their livelihood. Hence, a large number of them mistrust the system based on their past experiences (e.g. “knowledge-based trust” by Lewicki & Bunker, 1996).

Implications for academicians

This study tried to understand and evaluate trust in an institutional context. This approach has significant merits and is better able to explain the complexities of trust. Firstly, this study demonstrated the institutional context of trust by explaining the impact of clash of institutional logics on trust. A key strength of institutional literature is its coherent appreciation of the facets of *legitimacy* (e.g. Glynn & Abzug, 2002; Greenwood & Hinings, 1988; Oliver, 1991; Sherer & Lee, 2002; Suchman, 1995). This study also appreciates the independent influence of perceived *legitimacy* or appropriateness of behavior on patterns of trust across of subgroups. The nurses and support staff mistrusted the system and such mistrust is consistent with Oliver (1991) who hypothesizes:

The lower the degree of institutional norms or requirements with organizational goals, the greater the likelihood of organizational resistance to institutional pressures (p. 164).

In the context of this study the shared cognitive scripts of the various competing institutions reveals a significant clash of institutional logics. The clash between the *managerial or corporate logics* and the *logics of empathy and benevolence* at varying levels creates a feeling of mistrust in the lower echelons of the organization in Taber. The objective of efficiency that dictates the administrators makes them clash with the nursing and support staff who do not have to work under the pressures of budgetary and monetary limitations. Such norms of social *legitimacy* are best explained through institutional logics and have an impact on the dynamics of trust. It is therefore argued that the appreciation of trust must be linked to the appropriateness of behavior, and that in turn leads to legitimacy. Such appropriateness of behavior is explained by institutional logics.

Secondly, in this study I have demonstrated the variance of trust across subgroups. The findings of this study suggest that the dynamics of efficiency and rationality need not inspire trustworthiness in the organizational actors at the lower end of the hierarchy. However, such dynamics of *ability or managerial or corporate logics* tend to be critical to inspire trustworthiness in the upper echelons of power. This variance is perhaps explained by the differing roles of the managerial staff and professionals as opposed to the rest of the employees. The higher echelons of power are required to demonstrate financial prudence and are accountable for corporate efficiency. However, this requirement is absent or required to a lesser degree to people lower in the organization. I argue that there may also be other such phenomena that account for varying patterns of trust. This finding needs deeper probing and needs to be empirically tested in multiple settings before it can be considered generalizable.

And finally, this study reveals that as individual interests are not captured by institutional logics, sharing similar institutional logics may not necessarily lead to trust even if the behavior is considered desirable. It is therefore argued that any study to understand trust must also take into consideration the perceived benefits of the trusting party in the new system. Appropriate behavior is important but not an adequate requisite for trust. The “rational choice model” (Kramer & Tyler, 1996), “self interested behavior of agents” (Hendry, 2002) and the role of “interests” (Greenwood & Hinings, 1996) also impacts trust in the context of change.

Implications of this study for practitioners

Trust is important in times of change. However, trust is a complex and multifaceted phenomena and is difficult to evaluate. Even though managers recognize the importance of trust in times of change, they are often unable to unravel the antecedents of trustworthy behavior. Some implications of the findings of this study for practitioners are as follows:

- (1) Trust is an important issue in times of change. Hence, any perceived mistrust in the organizational actors or the organization has a catastrophic impact on the willingness of organizational members to support the new organizational objectives. In this study, I explained how the *change followers* do not trust the intentions of the *institutional entrepreneurs*. Similarly the *institutional entrepreneurs* and *implementers* do not trust the ability of the *change followers* to think rationally. This mistrust within certain members in turn shows a lack of relatedness and cohesion required by the organization to successfully implement such changes. This lack of

organizational social capital (e.g. Leana & Buren, 1999) suggests that these inadequacies need to be addressed appropriately.

- (2) Types of trust and levels of trust vary across the organization based on professional affiliation and institutional dynamics. Such dynamics of collective trust (e.g. Kramer et al., 1996) and social representation (e.g. Moscovici, 1963, 1988) are supported by literature. The *institutional entrepreneurs* are more influenced by *managerial or corporate logics*. They are perplexed and cannot understand the cause of such distrust in the *change followers* who operate on *logics of empathy or benevolence*. The norms of appropriate behavior may vary across the organization. In this study the two predominant logics appeared to be the *managerial or corporate logics* and *logics of empathy and benevolence*. What makes perfect sense to one set of members need not necessarily imply that the entire organization is driven by similar norms of appropriate behavior. In this study I explained how this clash of institutional logics causes mistrust.
- (3) The past experiences of the organizational members of the organization can influence such feelings of trust in times of change (e.g. “knowledge-based trust” by Lewicki & Bunker, 1996). Hence, an organization must take pains to uphold the values of “integrity” in all interactions if it seeks a trustworthy image. The nurses and the support staff remember that the regionalization of health services had caused a significant number of job losses. This catastrophic quality of mistrust (e.g. Burt & Knez, 1996) was

evidenced even in this study. Hence, their past experiences inculcate a sense of fear in their mind that these changes may impact them adversely.

- (4) Certain institutional actors may be prone to trust or mistrust the organization based on their perceived gains or losses in the new system (e.g. Tyler & Kramer, 1996). Hence, power-relationships impact trust in times of change. It is important to understand the importance of “self-interested behavior of agents” (e.g. Hendry, 2002) and “interests” (e.g. Greenwood & Hinings, 1996) whenever any changes are proposed. My findings suggest that the physicians trust the new initiatives as they perceive it to be in their best interests. Conversely, the nurses perceive that these changes would make them work under the physicians. Hence, they are more likely to mistrust these initiatives.
- (5) The organizational members must consider the actions of specific organizational actors legitimate if they are to support such changes. Such legitimacy depends upon the perception in the members that the organization upholds the correct values and principles (e.g. Suchman, 1995). In this study, the *change followers* believe that the *institutional entrepreneurs* were only pretending to act in the interests of better healthcare delivery but were actually driven by the dynamics of efficiency. They did not consider such dynamics of efficiency legitimate cause for change.
- (6) Conversely, if some institutional actors perceive such appropriate behavior detrimental to their self-interests, even legitimate actions of an

organization may not inspire trustworthiness. In this study I explained how the nurses were using the *logics of empathy and benevolence* as a mere veil to disguise their fears of a loss of status under the new arrangement.

- (7) The lack of openness and not taking into consideration the feelings and opinions of the lower hierarchy of the organization also created mistrust in them (e.g. Mishra, 1996). Hence, effective two-way communication is also considered important for trustworthiness. In this study, the middle-level managers and nurse-managers spoke of the difficulties in the process of change. One of them explicitly categorized it as a “trust issue for change” where people are suspicious and hence more communication was needed.
- (8) Any over emphasis of the organization on legitimization may prove to be a double-edged tool. The top management may risk them being perceived as “clumsy actors”, “nervous actors” or “overreacting actors” in their attempt to prove legitimacy (e.g. Ashforth & Gibbs, 1990). The use of symbols and metaphors are often utilized by organizations to attain legitimacy e.g. “Wellness Model” was used by the organization. However, the mere change of institutional names (e.g. Meyer & Rowan, 1991) and copying such models of healthcare delivery that exist elsewhere and are considered effective (e.g. Martinez & Dacin, 1999) does not necessarily inspire trustworthiness.

Conclusion

A study of trust in an institutional context explains the dynamics of trust more coherently. I drew on some of the leading literature in the fields of trust and institutional theory to explain one such framework. I do not intend to condemn or alternately legitimize either approach when I evaluate their respective strengths and inadequacies. Rather, it has been my intention to understand the construct of trust in an institutional context and discuss the variance in trust across the subgroups of an organization. This variance in patterns of trust is explained by various factors which primarily revolve around the analogies of institutional logics, perceived gains or losses in the transaction, perceptions of trustworthiness based on previous interactions and the perceived legitimacy of such actions amongst the various organizational actors in the research setting.

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APPENDIX A

Faculty of Management, University of Lethbridge Taber Integrated Primary Care Project - Research Questions

Organizational Change

The changes occurring within the Taber region with respect to the integration of health care delivery involve a movement from the current method of health care delivery to an integrated or “new” method. The Faculty of Management Research Team is examining three different levels of information about health care to help us evaluate the changes that are occurring with the Taber Project. The general level of information that we are looking for is your perception of the philosophies and initiatives for delivery of health care that have come from the health care industry in the province of Alberta. The next level of information is your perception of how these philosophies and initiatives have influenced health care delivery in the Chinook Health Region. The last level of information is your perception of how these philosophies and initiatives have influenced health care delivery in the Taber region and specifically, your responsibilities in the Taber region. We will ask these questions for the health care system as it is practiced today and then for the new system of integrated health care delivery.

Please note that we are asking for your opinions only; all information that we receive from you will remain confidential. Only aggregated information will be used in our final report thereby making it impossible to identify any of your opinions. Your opinions are important to us and will help us in our study of the Taber Integrated Primary Care Project. If you wish to receive the final report containing the aggregated and

summarized findings, please notify a member of the University of Lethbridge Taber Project Research Team.

Overall Organizational Level

1. In the current system, how would you define the nature of the health care industry and the general concern of people working in health care? How would you describe the overall mission of the health care system in Alberta?
2. How would you describe your role as a health care provider within the system?
3. In the current system, how is work organized, how does work get accomplished, and how do people interact?
4. What are the criteria used for performance evaluation? How do people know whether their work is effective or ineffective in the health care industry?
5. What about outsiders and decision makers (administrators, politicians, public policy analysts) what criteria would they use to assess the effectiveness of the system?

Chinook Health Region (CHR) Level

1. Please describe the organization of the CHR in terms of the structure and units.
2. How would you describe the CHR's mission and scope of practice?
3. In the current system in the CHR, how is work organized, how does work get accomplished, and how do people interact?
4. What are the criteria used for performance evaluation in the CHR? How do people know whether their work is effective or ineffective?

5. How do people outside of the CHR (politicians, economists, consumers) evaluate the effectiveness of the current system?

Taber Project/Individual Level

1. How would you describe the Taber Integration Project in terms of overall mission and scope of practice?
2. In the new system in Taber, how will work be organized, how will work get accomplished, and how will people interact?
3. What criteria will be used to evaluate the success of the new project in Taber?
How will people know whether their work is effective or ineffective?
4. How will people outside of the health care system (politicians, economists, consumers) evaluate the effectiveness of the Taber integration project?
5. Are there any other issues we have not touched upon that you feel are important for us to consider with regard to the Taber Integration Project?

APPENDIX B

INTERRATER RELIABILITY QUESTIONNAIRE

Judge code _ _ _

1. Did *ability* as a theme impacting trust emerge in the interview?

Yes Somewhat No

2. Did *benevolence* as a theme impacting trust emerge in the interview?

Yes Somewhat No

3. Did *integrity* as a theme impacting trust emerge in the interview?

Yes Somewhat No

4. According to you, which attribute impacted trust the most in the interview?

Ability Benevolence Integrity

5. What is your level of confidence in your judgment?

1 2 3 4 5 6 7

Not confident

Very confident